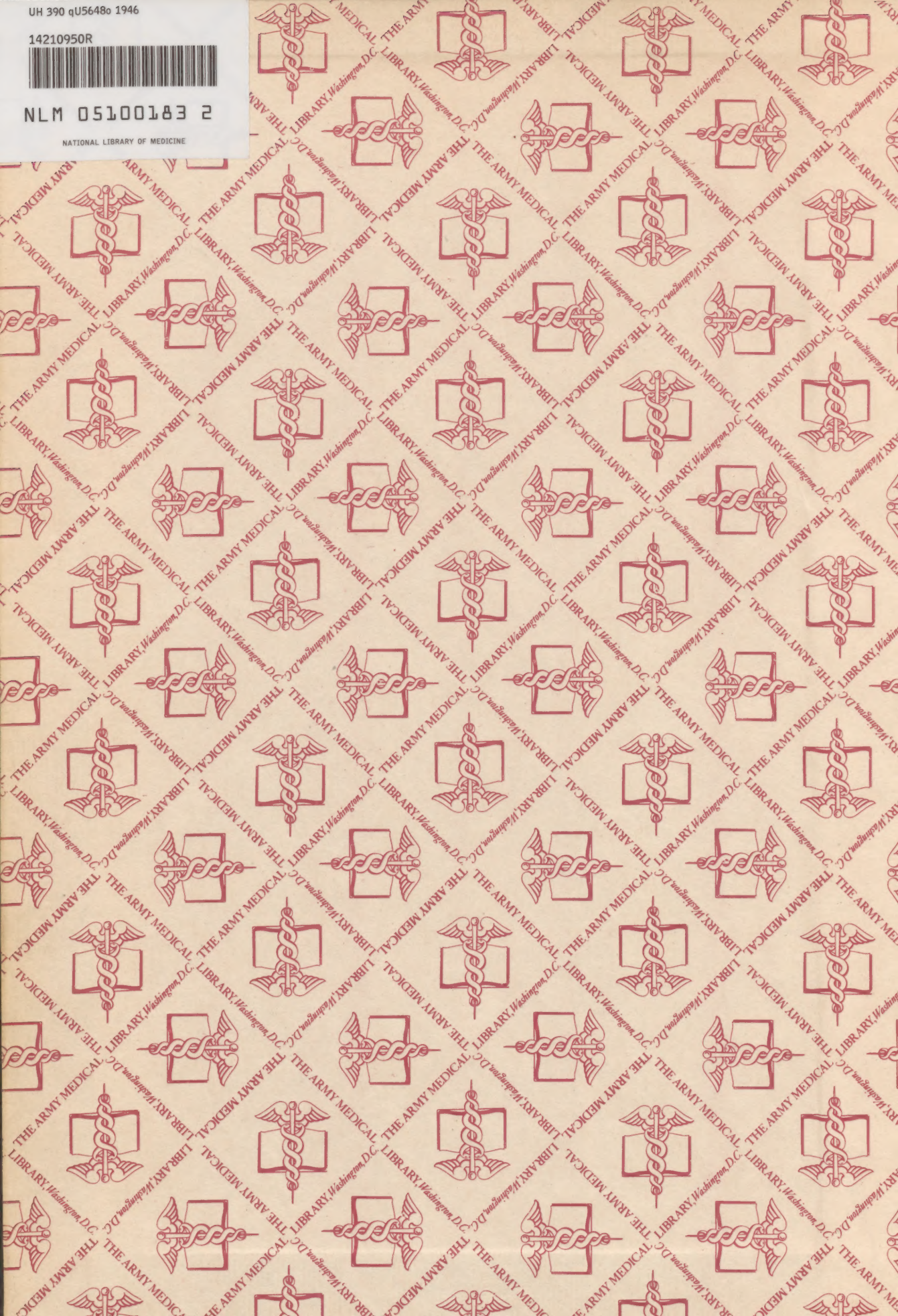

THE ORGANIZATION OF THE MEDICAL DEPARTMENT IN THE ZONE OF THE INTERIOR

PART I: The Office of The Surgeon General

PART II: The Service Commands and General Hospitals

by

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and

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This monograph is being made available in manuscript form pending the completion of the official History of the Medical Department in World War II, and must be considered as a draft subject to final editing and revision. Persons finding errors in facts or important omissions should communicate with the Historical Division, Army Medical Library, Washington 25, D. C.

WAR DEPARTMENT
OFFICE OF THE SURGEON GENERAL
30 June 1946

FOREWORD

The following account is a survey of Medical Department organization as it developed at headquarters (Office of The Surgeon General) and in the corps areas or service commands, from the entry of the United States into World War II to the period of demobilization. The Office of The Surgeon General is considered to include its field installations. Elements of the local structure which will be dealt with in considerable detail are the corps-area or service-command surgeons' offices and the general hospitals, including certain related establishments (the regional hospitals and hospital centers). Less space will be devoted to the post surgeons' offices. Other agencies, such as the convalescent and station hospitals and the medical services attached to tactical forces, will be mentioned only incidentally.*

*Captain Morgan is responsible for the first six chapters of this work; Dr. Wagner, for the following six. The Conclusion is a joint product.

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PART I

THE OFFICE OF THE SURGEON GENERAL

CHAPTER I

ORGANIZATION OF THE OFFICE OF THE SURGEON GENERAL IN TIME OF PEACE

The organization of the Office of The Surgeon General in time of peace, as exemplified during the period from 1931 to 1935, was simple yet complete; in it lay the genesis of most later developments.

The Surgeon General exercised "administrative supervision over the Medical Department... [as the]...adviser to the War Department upon all medical and sanitary affairs of the Army."[1] As responsible head of the department he reserved to himself final action under the War Department on all matters relating to the formulation of policy, planning, estimates for appropriations, recommendations for legislation, relations with other branches of the Army and correspondence with the Chief of Staff, the Secretary of War, or the President.[2] In actual operation the office was administered and coordinated by an Executive Officer, acting under instructions of The Surgeon General.[3]

The mission of the office was "to supervise the health of the Army, including the dental and veterinary service, and to administer the Army Medical Museum and the Army Medical Library."[4] This mission was normally accomplished through the divisions of the office under the direction of The Surgeon General, although other office units were created when needed for the performance of special duties.[5] In 1935 the office was organized into five divisions:[6] the Administrative, Finance and Supply, Military Personnel, Planning and Training, and Professional Service Divisions. These were further divided into subdivisions.

The Administrative Division enjoyed the most direct contact with The Surgeon General. It administered all general affairs of the Medical Department not specifically assigned to other divisions, was the coordinating agency between the divisions, and managed the general office service.[7] The Office Management Subdivision handled all aspects of office civilian personnel. It prepared all estimates for printing and binding and managed all funds allowed for publications, supervised local hospital funds, managed the Central Hospital Fund, and administered the admission of patients to the Army and Navy General Hospital. In addition to these duties, the subdivision edited the Army Medical Bulletin. Two other subdivisions completed the work of the Administrative Division. The Mail and Record Subdivision received and distributed all official correspondence and maintained the reference files. The Office Equipment and Circulation Subdivision was accountable for all office supplies; it distributed orders within the office and circular letters of the Department, and was responsible for all mimeograph work.[8]

The Finance and Supply Division managed the fiscal and supply business of the Medical Department. The chief of the division, as the Fiscal Officer for The Surgeon General, was responsible for

preparing and defending all budget estimates. The Finance Subdivision assisted the chief in the formulation of estimates for appropriations and kept the office control accounts for appropriations granted. The Supply Subdivision supervised the purchase, storage and distribution of medical supplies and equipment. All planning for industrial preparedness for medical supply in time of war was performed by a Procurement Planning Subdivision. Specifications for all items were developed in the Specification Subdivision. The Cost Accounting Subdivision compiled costs of operating Army hospitals, preaudited the value of supplies issued to other services, and made estimates of funds necessary to replenish the stock issued. The examination and records of claims against the Medical Department was the chief function of the Claims Subdivision. A Civilian Personnel Subdivision supervised the over-all management of civilian employees in depots and other field installations.[9]

The Military Personnel Division was the advisor to The Surgeon General in all matters relating to the selection, classification, and disposition of commissioned and enlisted personnel. The Commissioned, Enlisted, and Reserve Subdivisions managed and supervised the functions of the division.[10]

All planning and training policies were developed in the Planning and Training Division. These included Regular Army and Reserve activities and the routine business of the Medical Department relating to the Civilian Conservation Corps. The division was divided into the Planning and Training Subdivisions. The Planning Subdivision performed important duties in connection with Medical Department preparedness. It prepared war plans, tables of organizations and tables of basic allowances. It supervised the development of field equipment and formulated manuals and administrative regulations. It was the pilot-house for Medical Department activities. The Training Subdivision planned training activities and supervised their execution.[11]

The Professional Service Division was the largest, the most complicated, and the most widely extended of all the divisions in the office. It was charged with "the administrative management of the professional services rendered by the Medical Department."[12] The following eight subdivisions were employed to carry out the mission of the division during this period: Medicine, Preventive Medicine, Hospital, Statistics, Army Medical Library, Dental, Veterinary and Nursing. Three of these subdivisions were more administrative than professional, and the chief of these non-professional units was the Hospital Subdivision. Its functions were to supervise the administration of general hospitals and to exercise advisory supervision over the administration of other hospitals and dispensaries; to prepare preliminary plans for new hospitals; and to offer advisory supervision over the preparation of definitive hospital plans, new construction, or maintenance

and repair of existing hospital facilities. The Statistics Subdivision was the second administrative unit in the division. It received and corrected reports of sick and wounded, compiled vital statistics, and edited the Annual Report of The Surgeon General. The third administrative function assigned to the division was the supervision of the Army Medical Library. In actual operation the library was administered by the officer in charge of the Library Subdivision. All references were made to the Army Medical Library; the designation as a subdivision appears to be purely a matter of organizational convenience.[13]

In addition to the purely administrative functions, three non-medical specialties were included within the Professional Service Division. The Dental, Veterinary and Nursing subdivisions were responsible for the administrative, professional, and advisory supervision of matters relating directly to these phases of professional activities. In a large measure they constituted separate areas of autonomy.[14]

In 1935 the Professional Service Division was divested of these six subdivisions. The functions, records, and personnel of the Hospital Subdivision which related to the planning, construction, maintenance and repair of hospitals, were transferred to the Planning and Training Division in August 1935.[15] All purely professional matters relating to hospitalization were retained by the division, but the Hospital Subdivision completely disappeared as a unit. In November the Statistical, Library, Dental, Veterinary, and Nursing Subdivisions were established as divisions.[16] This left the division with two subdivisions. The Medicine Subdivision developed medical and surgical policies, including plans for new methods of treatment, rendered professional opinions on medical matters, and approved selection of personnel for key professional assignments. The Preventive Medicine Subdivision formulated physical standards for military personnel, reviewed reports of physical examinations, and exercised advisory supervision over military sanitation, the control of communicable diseases, and Army laboratories. It maintained the necessary liaison with the Quartermaster Department and with the Public Health Service.[17]

With the changes of 1935 the office reverted to an organizational pattern which had been in effect for a number of years prior to 1931.[18] The claim that "the results of this reorganization have been highly satisfactory"[19] appears to have been sustained by the fact that no further major change was made in the peace years. The basic organization continued to consist of the Administrative, Finance and Supply, Military Personnel, Planning and Training, Professional Services, Statistical, Library, Dental, Veterinary, and Nursing Divisions.[20]

The first break in this structure was made during the period of the "limited emergency" when important changes were made to better coordinate and administer the large volume of work incident

to the national defense program.[21] All reorganization in the period immediately preceding the war related directly to the expanding functions and duties of the professional services. In May 1940 the Professional Service Division, which only a year before had reported a "satisfactory bracketing of activities into definite subdivisions...impracticable,"[22] was reorganized into the Preventive Medicine; Medicine and Surgery; Physical Standards, US Military Academy and Regular Army; Physical Standards, Officers Reserve Corps and National Guard; Army Medical Museum; and Miscellaneous Subdivisions.[23] In addition, it continued to supervise the "professional service rendered by the Army Medical Corps."[24] The increasing scope and amount of professional work[25] to be accomplished led to the establishment, in February 1941, of a Food and Nutrition Subdivision[26] and the re-establishment of a Hospitalization Subdivision.[27] The appended organization charts for June 1936 and March 1941 illustrate the major changes actually made during time of peace.[28]

It was apparent that the growing pressure to coordinate and develop plans and policies for the operation of military hospitals would require full divisional stature for that phase of professional activities.[29] Similarly, planning in the field of preventive medicine promised to be of greater importance as the possibility increased for direct participation in the war. The Professional Service Division, therefore, was again reorganized, and the activities of the Hospitalization and Preventive Medicine Subdivisions were transferred from the division and made full divisions on April 18, 1941.[30] The Hospitalization Division was charged with development and promulgation of policies and the treatment of military personnel. It was responsible for the supervision of named general hospitals and the advisory supervision of all other Army hospitals. The division was authorized to develop and control a system of bed credits to regulate the flow of patients to the general hospitals and it directed the assignment to general hospitals of patients transferred from overseas. Two subdivisions were organized to perform these duties.[31]

The Division of Preventive Medicine was created to supervise all activities related to the "prevention or control of disease among troops and the maintenance and conservation of the health of the Army."[32] To achieve these objectives wide liaison responsibilities were imposed.[33] Five subdivisions were provided to fulfill its mission:

> Epidemiology, Disease Control, and Industrial Hygiene
> Sanitation, Hygiene, and Laboratories
> Sanitary Engineering
> Venereal Disease
> Medical Intelligence and Tropical Medicine[34]

The emphasis on the professional character of the work of the Professional Service Division was reaffirmed in the same reorganization by the establishment of a Liaison Subdivision to further cooperate with civilian and other governmental agencies.[35]

The divisional organization of the Office of The Surgeon General was supplemented by a number of standing boards and other units designed to perform special duties.[36] The functions of these units were limited to specific problems and the necessary personnel was designated in office orders.[37] In 1935 eight boards and two committees were in active operation;[38] by 1941 this number had increased to fourteen special boards. Boards were established to review manuscripts for publication; to review books and periodicals for procurement; to examine procurement specifications; to approve civilian efficiency ratings; to examine applications for appointments in Army hospitals; to consider and grade examination papers for increased enlisted grades; to consider candidates for promotion to assistant superintendent and chief nurse, Army Nurse Corps; to consider memorials, tablets and portraits of Medical Department officers; to study methods for simplifying administrative detail in the Medical Department; to determine annual and general ratings of Medical Department officers; to survey the Reference Library; to revise the Medical Department Supply Catalog; to supervise chest x-rays of all recruits and draftees; and to coordinate Medical Department research.[39] The first five of the above boards and the two committees were in continuous existence from 1935 to 1941.[40] Liaison officers increased from three to five during the same period, and in 1941 were assigned to: The Personnel Bureau, TAGO; the American Red Cross; the Procurement Division, Treasury Department; the Quartermaster Corps Technical Committees; and the Health and Medical Committee, Federal Security Agency.[41] The Property Officer and Custodian of the Central Hospital Fund performed continuing functions.[42] In 1941 a Military Intelligence Section was added.[43]

NOTES FOR CHAPTER I

[1]Army Regulations 40-5, Par 3., Jan 15, 1926.

[2]SGO Office Order 76, July 30, 1931; Office Order 1, Jan 2, 1935.

[3]Ibid.

[4]Ibid., 1935, Par 2.

[5]Ibid., 1935, Par 3.

[6]Tables of Organization 707-P, Approved July 23, 1931.

[7]SGO Office Order 1, Sec II, 2 Jan 1935.

[8]Ibid., pp 4-5.

[9]Ibid., pp 5-6.

[10]Ibid., p. 6.

[11]Ibid., p. 7.

[12]Ibid., p. 7.

[13]AR 40-405

[14]SGO Office Order 1, 2 Jan 35, pp 7-8.

[15]SGO Office Order 79, Aug 21, 1935.

[16]SGO Office Order 114, Nov 29, 1935.

[17]SGO Office Order 1, Jan 2, 1935, par 29.

[18]SGO Annual Report 1936, p. 122.

[19]Ibid., p. 123.

[20]Annual Reports, SGO, 1936-1940.

[21]SGO Annual Report 1941, p. 126.

[22]SGO Annual Report 1939, p. 190.

[23]SGO Office Order 51, May 9, 1940; See Chart II of this study.

[24]SGO Annual Report, 1940, p. 153.

[25]SGO Annual Report, 1940, p. 193.

[26]SGO Office Order 31, Feb 17, 1941.

[27]SGO Office Order 32, Feb 17, 1941.

[28]See Charts I and II of this study.

[29]SGO Annual Report 1941, p. 169.

[30]SGO Office Order 87, April 18, 1941; See Chart IV of this study.

[31]Ibid., Annual Report of the Operations Service to The Surgeon General, 1942 (SGO Historical Division 319.1-2.)

[32]SGO Annual Report 1941, p. 173 (SGO Historical Division).

[33]Ibid.

[34]Ibid., pp 174-181.

[35]Ibid., Charts III and IV.

[36]SGO Annual Report 1939, p. 163; 1940, p. 158.

[37]SGO Office Order 1, Jan 2, 1935, par 40; SGO Office Order 1, Jan 21, 1941, par 52.

[38]SGO Office Order 1, Jan 2, 1934, pp 10-11.

[39]SGO Office Order 1, Jan 2, 1941, parts 53-57; 60-65; 67-71.

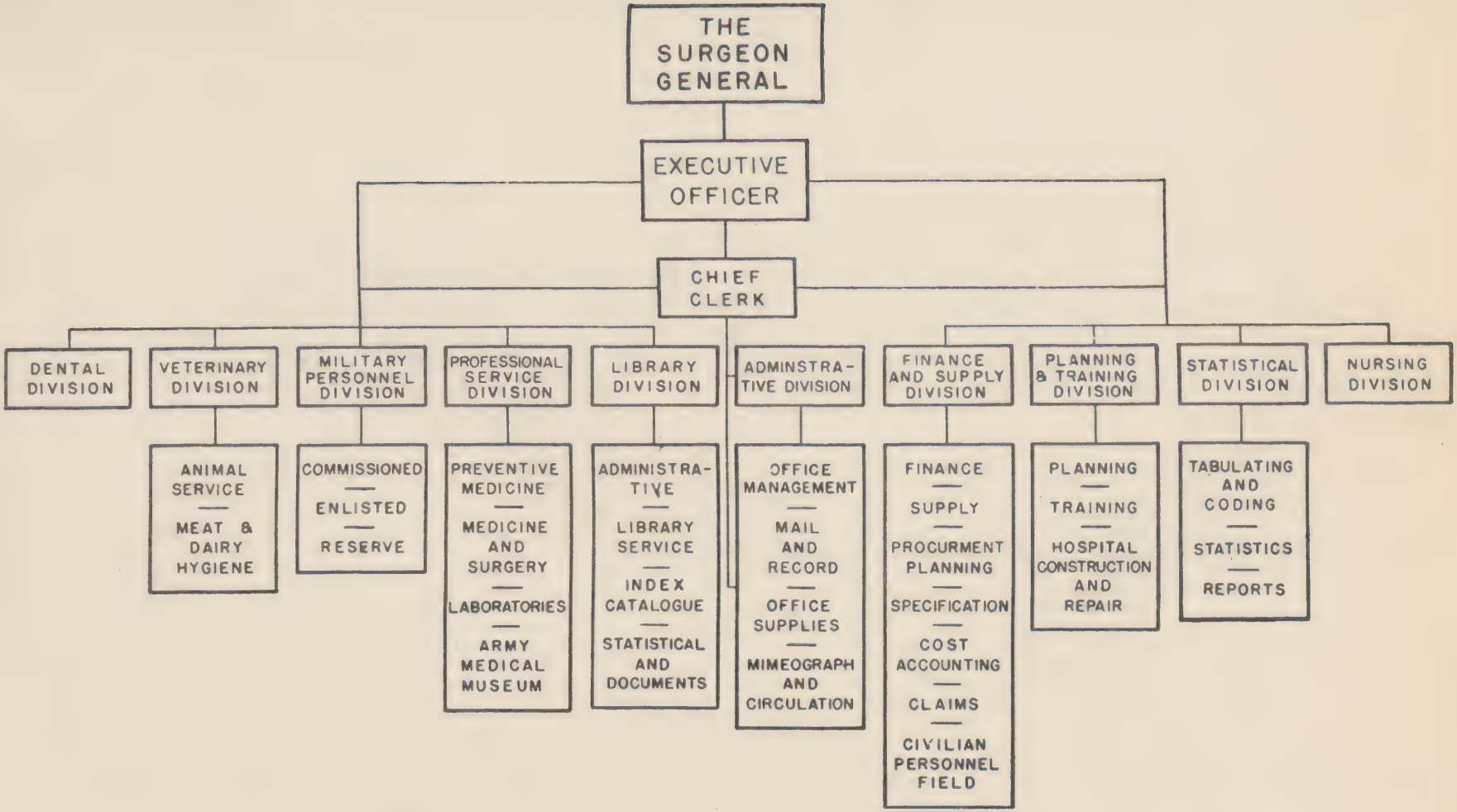
[40]SGO Office Order 1, Jan 2, 1935, pp 10-11.

[41]SGO Office Order 1, Jan 2, 1941, par 66.

[42]Ibid., p. 10.

[43]SGO Office Order 1, Jan 2, 1941.

CHART I

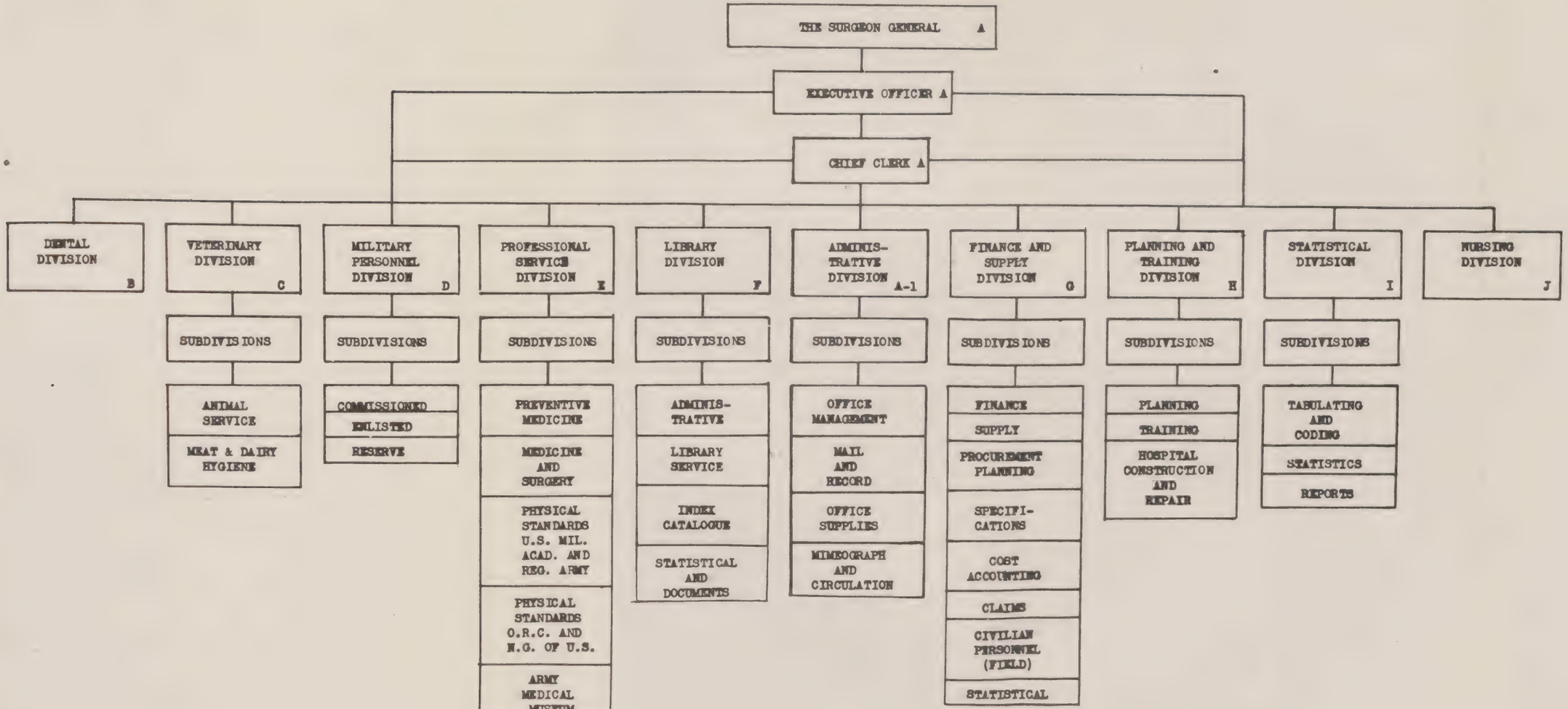


Organization chart, Office of The Surgeon General, United States Army, Annual Report 1936, page 123.

MASTER CHART

PEACETIME ORGANIZATION CHART

SURGEON GENERAL'S OFFICE, WAR DEPARTMENT



APPROVED:

James C. Magee
Major General, U.S. Army
The Surgeon General

March 1, 1941

CHART II

FUNCTIONAL ORGANIZATION CHART
OFFICE OF THE SURGEON GENERAL, WAR DEPARTMENT

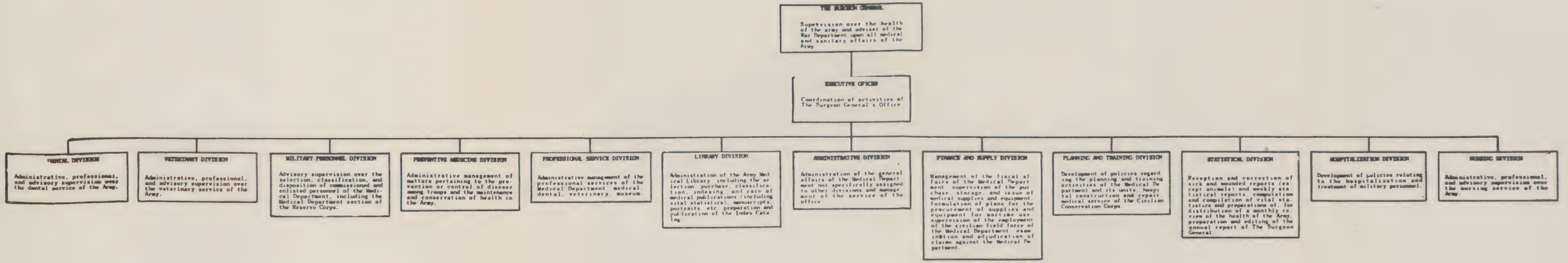


CHART III

APPROVED:
James C. Magee,
Major General, U.S.Army.
The Surgeon General.
May 15, 1941

48 7878

MASTER CHART

ORGANIZATION CHART

OFFICE OF THE SURGEON GENERAL, WAR DEPARTMENT

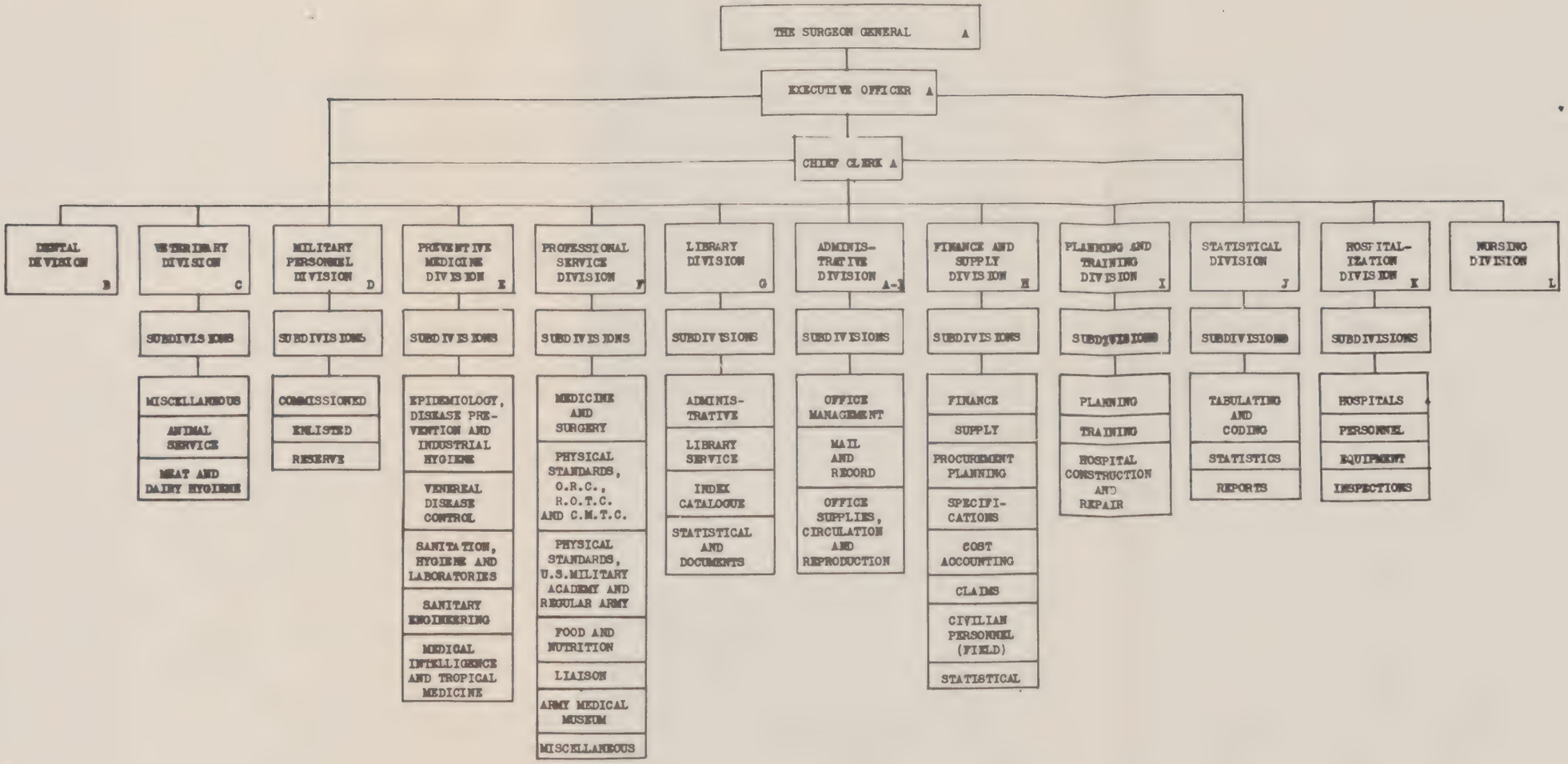


CHART IV

APPROVED:

James C. Magee,
Major General, U.S. Army,
The Surgeon General

May 15, 1941.

CHAPTER II

EARLY WAR-TIME ORGANIZATION - FIRST REORGANIZATION UNDER THE SERVICES OF SUPPLY

At the outbreak of hostilities on December 7, 1941, the Office of The Surgeon General consisted of 12 major divisions. It was staffed by a force of 112 officers and 778 civilians. The office was organized, under The Surgeon General and his Executive Officer into the Administrative, Military Personnel, Planning and Training, Finance and Supply, Statistical, Library, Professional Service, Preventive Medicine, Hospitalization, Dental, Veterinary, and Nursing Divisions. The duties of each division were indicated in the functional chart of the office published in December 1941.[1] [See Chart V.] The mobilization program had placed enormous demands upon the office; the entry into war promised an even greater volume of work to be done.

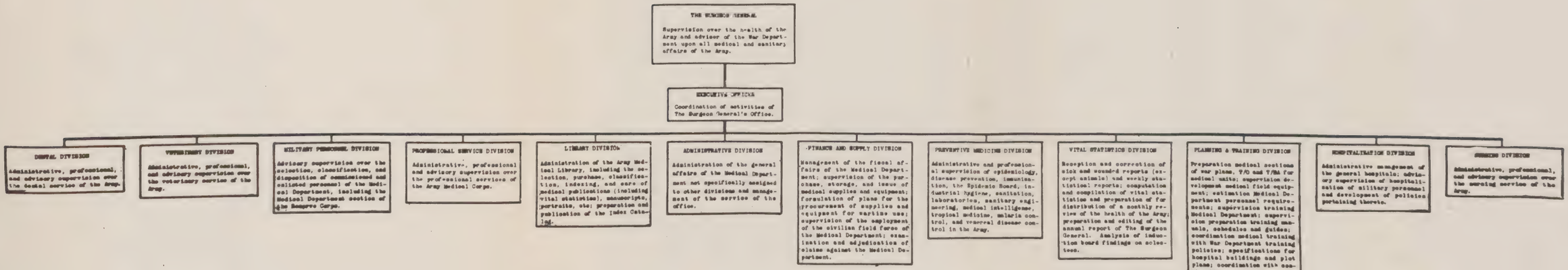
Organization expanded piece-meal in the effort to meet the crisis. The greatly increased amount of work in pathology incident to mobilization[2] expanded the activities of the Army Medical Museum, and that subdivision of the Professional Service Division was created as a separate division in January 1942.[3] The rapid growth of training activities, due to the great expansion in the field forces and the projected needs for medical units and troops, dictated a stronger organization for training in the office; and the Training Subdivision was detached from the Plans and Training Division. A new Training Division composed of three functional units was created to include the Officers Training, Enlisted Training, and Publications Subdivisions.[4] The increased demands for hospital construction gave rise to another new division, when the Hospital Construction and Repair Subdivision of the Planning and Training Division was reorganized into the Hospital Construction Division.[5] The number of divisions was thus increased to 15. Some less important revisions were made under the division level. The Professional Service Division established separate branches for Medicine, Surgery and Neuropsychiatry in order to handle more expertly and with greater facility the problems arising within these specialties. The Preventive Medicine Division established a new Occupational Hygiene Branch to supervise a program for the protection of workers against industrial and health hazards in the growing number of industrial plants with which the Army had contracts. Public relations and historical activities were given branch status and added to the Administrative Division.[6]

The sprawling organization of the office provided for necessary decentralization of functions and operations but made cooperation between the divisions difficult. Some attempt to bridge the gap was made early in 1942 when The Surgeon General directed that the Division Chiefs meet together at frequent intervals, ... "to disseminate information in order to promote orientation and assist

in attaining intelligent and cooperative prosecution of our efforts as a unit."[7] He considered it "apparent that ... divisions should be combined under fewer and more comprehensive headings."[8] A logical opportunity for such reorganization presented itself when the Office of The Surgeon General was made an operating division[9] of the newly created Services of Supply.[10] No specific directive was published by higher authority to reorganize, but the office was made to conform with the organizational pattern of Headquarters, Service of Supply on March 26, 1942.[11] "All divisions and branches were organized, under The Surgeon General, a Deputy Surgeon General, and the Executive Officer, into nine services of equal functional level."[12] These services included the Finance and Supply, Professional, Preventive Medicine, Personnel, Administrative, Operations, Dental, Veterinary, and the Nursing Service. The major re-grouping of functions occurred in the organization of the Operations and Administrative Services. The Planning, Training, Hospitalization and Hospital Construction Divisions were brought together under the Operations Service. The Administrative Service included all the functions of the old Administrative Division together with important additions.[13] Two of its old subdivisions, Historical and Intelligence, were raised to divisional status and included in the new service. The Statistics, Army Medical Library and Army Medical Museum divisions were annexed without essential change of organization. In addition, two new and urgently needed divisions were created within the Administrative Service. The first of these was a new Civilian Personnel Division organized to centralize the management of all civilian personnel under the control of The Surgeon General. This responsibility had been a divided function. The Administrative Division was formerly responsible only for those civilians actually working in the office; it now added the control of those in the field installations who were previously under the jurisdiction of the Finance and Supply Division. Unification of these functions provided the necessary machinery for economical use of the increased number of civilians employed in the Medical Department.[14] The new Research and Development Division was the second addition to the Administrative Service. It centralized the elements of the research and development program, the separate phases of which had been allotted previously to other divisions of the office.[15]

The duties performed by each of the services and divisions subsequent to reorganization are indicated by the subdivisions set forth on the organization chart, approved March 26, 1942. (Chart VII).

FUNCTIONAL ORGANIZATION CHART
THE SURGEON GENERAL'S OFFICE, WAR DEPARTMENT

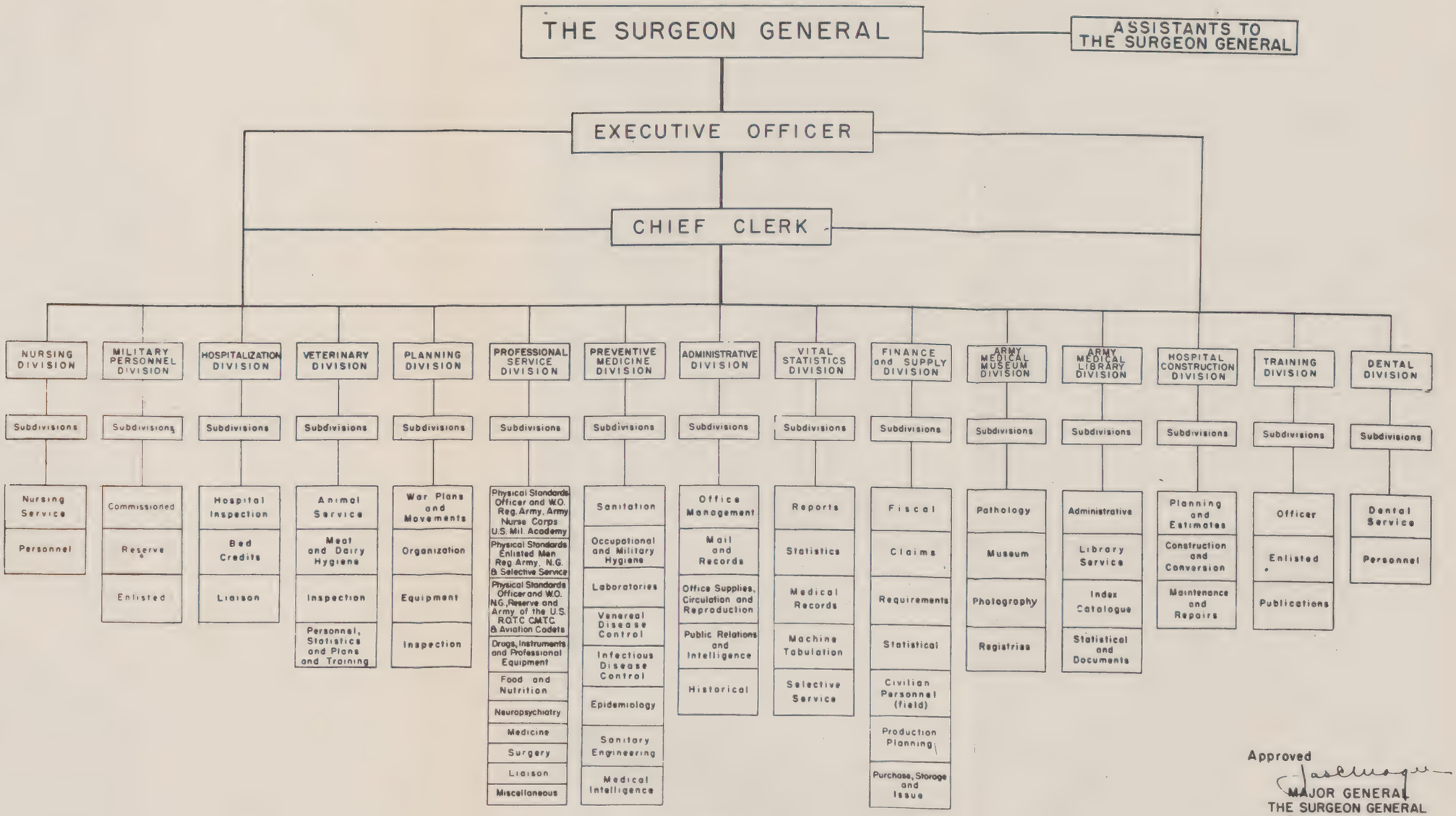


APPROVED:
James C. Magee
Major General, U.S. Army.
The Surgeon General.

December 20, 1941

CHART V

ORGANIZATION CHART
OFFICE OF THE SURGEON GENERAL
U. S. ARMY WAR DEPARTMENT



Approved
[signature]
MAJOR GENERAL
THE SURGEON GENERAL
February 21, 1942

CHART VI

Services of Supply
Office of The Surgeon General

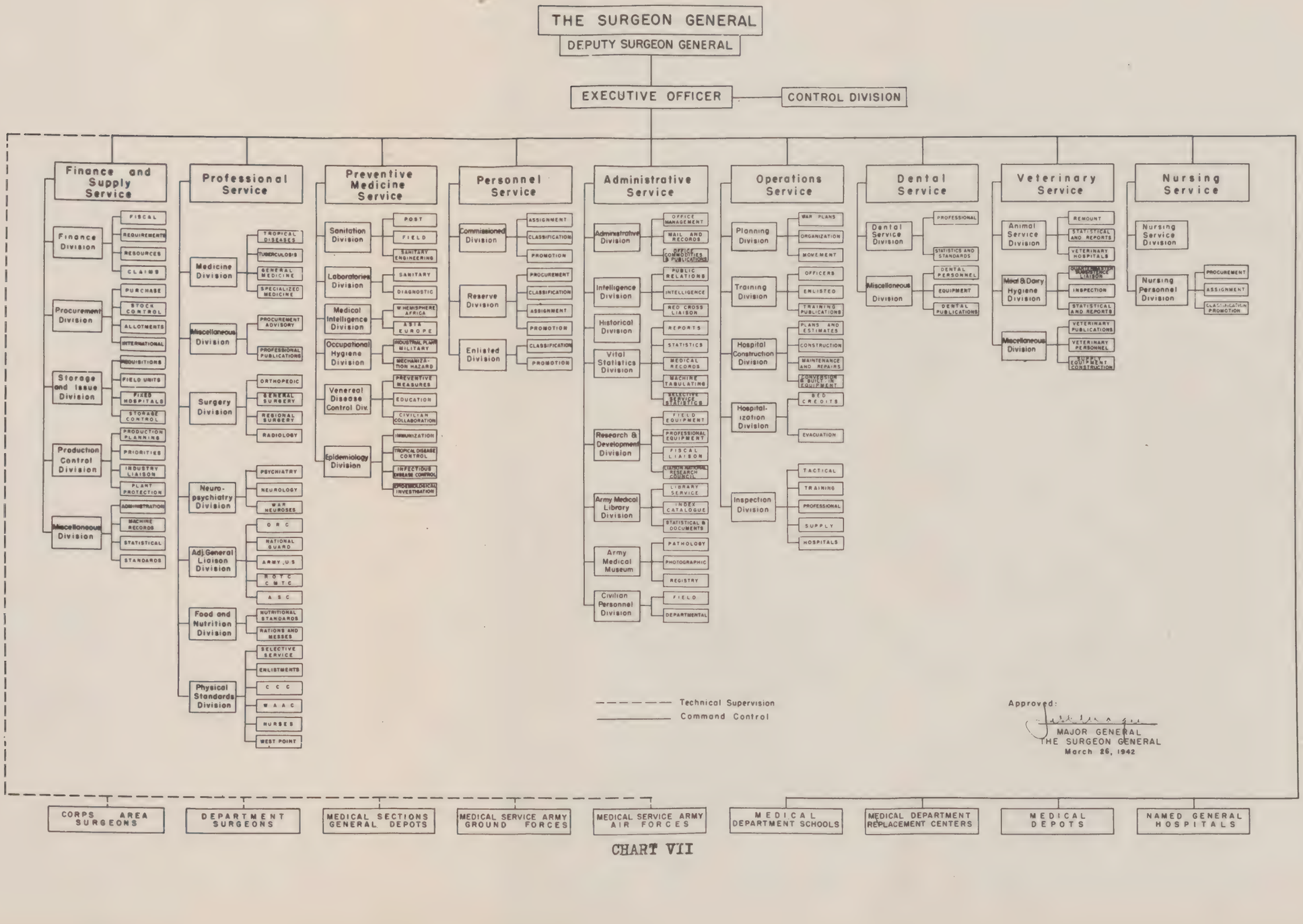


CHART VII

"In general the organization ... accomplished a functional consolidation of ... the increased activities of the office that had been emphasized and expanded by the war effort."[16] Further study was made to determine the activities actually performed by each division.[17] All divisions were directed by The Surgeon General "to supply data for a functional chart of the office ... to parallel the recently published organizational chart."[18] This data was consolidated by the newly created Control Division[19] into a chart, approved May 9, 1942, which confirmed the March reorganization and set forth the functions of all major divisions of the office.[20] (Chart VIII).

The organization of March had hardly gone into effect when an exhaustive study was initiated, in conjunction with Headquarters, Services of Supply, "to physically separate the fiscal and supply functions of the Finance and Supply Service ..., and to consolidate all fiscal functions ... into a separate Fiscal Division, in accordance with policies promulgated by Headquarters, SOS. This plan was adopted July 1, 1942."[21] The Chief of the Fiscal Division was redesignated as Fiscal Officer for The Surgeon General. Two branches were established to carry on the work of the new division: the Fiscal Subdivision and the Claims Subdivision.[22] The reorganization was not limited, however, to mere separation of fiscal and supply functions. The Supply Service itself was reorganized as follows: The Production Control Division became the Production Planning Division: current procurement was designated as a function of the Purchase Division; the Miscellaneous Division was abolished; and A Requirements Division was added. The Distribution Division remained unchanged.[23] The Defense Aid Subdivision had been redesignated the International Division in order to conform to the nomenclature of the general organization of the Services of Supply.[24] It was now given divisional status within the Supply Service.

A major change was made also in the position of the Army Medical Library and the Army Medical Museum. The then current appropriations act required that civilian personnel of these organizations be transferred from departmental to field status.[25] These institutions, therefore, were eliminated as divisions of the Professional Service and were given field status under the direct supervision of The Surgeon General on July 1, 1942.[26]

NOTES FOR CHAPTER II

[1]See Functional Organization Chart, Office of The Surgeon General, approved December 30, 1941. Chart V of this study.

[2]SGO Annual Report, 1941, p. 172.

[3]SGO Office Order 29, Jan 31, 1942.

[4]Annual Report of Operations Service to The Surgeon General, 1942, p. 3 (Historical Division, SGO, 319.1-2).

[5]SGO Office Order 1, par. 29, Jan 2, 1941.

[6]Inclosure to Memorandum for Director, Control Division, SOS, from Director, Control Division, SGO, as required by SPX 319.1, 9-24-42, SP 1CY-MP-R, Oct 6, 1942. (SGO SPMC 024.-1). See chart VI, approved Feb 21, 1942.

[7]Memo for Division Chiefs, SGO, Jan 6, 1942.

[8]Memo for Director of Control, Control Div, Hq SOS [not dtd, circa Dec 1, 1942] (SGO Historical Division SPMC 024.-1).

[9]Initial Directive for the organization of the Services of Supply, March 9, 1942, Chart D.

[10]WD Circular 59, March 2, 1942.

[11]Annual Report of TSG to the CG, ASF, for 1942, p. 28 (Historical Division, SGO 319.1-2).

[12]See footnote 8; SGO Organization Chart, approved March 26, 1942. Chart IV.

[13]SGO Office Order 119, April 29, 1942.

[14]See Footnote 8.

[15]SGO Office Order 123, May 1, 1942 (actual order confirming the establishment of the Research and Development Division).

[16]Memo from the Director, Control Division, SGO to the Director of Control, Control Div, SOS, not dtd (Historical Division, SGO, 024.-1).

[17]Control Division Procedure Assignment No. "A" in files of Director, Control Division, SGO.

[18]SGO Office Memo, April 30, 1942.

[19]SGO Office Order 105, April 20, 1942.

[20]Chart VIII of the study; Control Division Procedure Assignment Number A, supra.

[21]SGO Annual Report to the Commanding General, Services of Supply, 1942, p. 28 (Historical Division, SGO, 319.0).

[22]SGO Office Order 230, June 26, 1942.

[23]SGO Office Order 340, Sept. 1, 1942.

[24]SGO Office Order 111, April 25, 1942.

[25]Memorandum from Control Division, SGO, "Report on Administrative Developments," cited in footnote 16.

[26]SGO Office Order 237, July 1, 1942.

FUNCTIONAL ORGANIZATION CHART
THE SURGEON GENERAL'S OFFICE, WAR DEPARTMENT

THE SURGEON GENERAL

Supervision over the health of the Army and adviser of the War Department upon all medical and sanitary affairs of the Army.

EXECUTIVE OFFICER

Coordination of activities of The Surgeon General's Office.

CONTROL DIVISION

Conducts a continuous review of the organization and administration and analysis of the progress reports of the various divisions of The Surgeon General's Office. Makes recommendations with a view to enhancing and expediting the output of each category of service furnished. Maintains liaison with the Control Branch, S.O.S.

FINANCE AND SUPPLY SERVICE

Finance Division. Computes requirements of Medical Department supplies, equipment, and raw materials and keeps data on Medical Department item resources. Audits claims against the Medical Department and prepares contracts for spectacles and laundry service. Prepares and defends estimates; apportions and allots funds. Supervises procurement of storage space.

Procurement Division. Supervises procurement of all supplies and equipment for the Medical Department and for Defense Aid. Controls depot stocks and allots funds to procuring depots and to individual stations within the United States.

Storage and Issue Division. Develops and executes assembly of hospital and field units and supervises the shipment of controlled items. Maintains record of stocks in depots, in transit, and in hands of troops.

Production Control Division. Conducts industrial surveys and production studies. Represents The Surgeon General in priority matters; coordinates requirements to production capacity, and advises in matters of plant expansion, plant protection, threatened shortages, etc.

Miscellaneous Division. Operates machine records and compiles all statistical data for the Finance and Supply Service. Supervises the standardization and specification of all standard Medical Department items and advises on conservation measures.

PROFESSIONAL SERVICE

Medicine Division. Promulgates policies governing practice of general and specialized medicine in the Army.

Miscellaneous Division. Provides professional advice governing purchase and distribution of drugs, dressings, instruments, etc., and determines upon the suitability for publication of all professional manuscripts submitted for review.

Surgery Division. Promulgates policies governing the practice of general and specialized surgery and radiology in the Army.

Neuropsychiatry Division. Sets forth the policies governing the Neuropsychiatric Service of the Army.

Adjutant General Liaison Division. Acts in medical advisory capacity to the Reserve and Officers' Divisions of The Adjutant General's Office.

Food & Nutrition Division. Coordinates and promulgates policies concerned with nutrition of military personnel and operation of soldiers' messes.

Physical Standards Division. Promulgates policies concerning physical standards and coordinates all medical problems pertaining to military personnel. Acts in advisory capacity regarding National Selective Service Headquarters' professional problems.

PREVENTIVE MEDICINE SERVICE

Sanitation Division. Initiates policies and handles problems pertaining to post and field sanitation, including the progress of water purification, waste disposal and disease bearing insect and vermin control. Advises on the procurement and assignment of personnel utilized under this specialty.

Laboratories Division. Formulates, advises and assists in the accomplishment of policies regarding the establishment, function, and operation of Medical Department laboratories, sanitary and diagnostic.

Medical Intelligence Division. Collects, correlates and files medical and sanitation information on foreign countries and prepares medical surveys on these countries for War Department use. Maintains maps on world distribution of communicable diseases and their current incidence.

Occupational Hygiene Division. Conducts a program of control and research in occupational hygiene in connection with the special health hazards encountered at Army operated industrial plants and incident to mechanized warfare.

Venereal Disease Control Division. Initiates policies and plans and assists in the selection and preparation of qualified personnel in conducting a program of venereal disease control at military stations.

Epidemiology Division. Establishes policies and procedures for the prevention and control of infectious diseases including the initiation and guidance of appropriate research activities to this end.

PERSONNEL SERVICE

Commissioned Division. Recommends assignment, reassignment and promotion of Medical Department officers of the Regular Army and also procures and classifies officers of the Medical Corps and Medical Administrative Corps. Maintains allotment control and station assignment records on Medical Department officers of all components.

Reserve Division. Processes for appointment and classifies all Medical Department officers of the Army of the U.S. and cooperates with the Procurement and Assignment Service in procuring them. Recommends the assignment of all Medical Department officers of the Reserve Corps and Army of the U.S.

Enlisted Division. Develops policies on procurement and distribution of Medical Department enlisted men. Recommends allotments of grades and ratings, prepares cadre assignments, and maintains personnel records and statistical data on enlisted men by organization and station.

ADMINISTRATIVE SERVICE

Administrative Division. Publishes and circulates all orders and instructions originating within The Surgeon General's Office and distributes and accounts for all property and supplies used therein. Operates a mail and records subdivision which handles all communications pertaining to The Surgeon General's Office, classifying, indexing, extracting, and maintaining a permanent file record of the same. Controls Central Hospital Fund and audits all hospital fund statements.

Intelligence Division. Maintains files of military intelligence reports which concern the Medical Department and its personnel, and necessary liaison with military intelligence agencies. Maintains public-relation contacts for The Surgeon General's Office, securing clearance of all military information to be announced or published. Maintains War Department liaison with the American Red Cross.

Historical Division. Collects, classifies and maintains indexes of material having historical interest and value to the Medical Department.

Vital Statistics Division. Receives and coordinates all sick and wounded records and receives and compiles statistics relative to the health of the Army. Collects data from induction physical examination reports; compiles and edits the Annual Report of The Surgeon General.

Research and Development Division. Coordinates the planning and execution of research, and the development of professional and field equipment and supplies pertaining to the activities of the Medical Department. Maintains liaison with the National Research Council.

Army Medical Library Division. Administers the Army Medical Library.

Army Medical Museum. Administers the operation of the Army Medical Museum.

Civilian Personnel Division. Administers the requisition, classification, assignment and compensation of all Civil Service personnel, departmental and field, employed by the Medical Department.

OPERATIONS SERVICE

Planning Division. Makes recommendations relative to medical service, hospitalization and designation of units for base, task and overseas forces. Prepares and revises Tables of Organization and Tables of Basic Allowances. Supervises development, testing and standardization of Medical Department field equipment.

Training Division. Establishes policies, formulates plans, supervises and coordinates the technical and field training for all commissioned and enlisted personnel of the Medical Department, including students in the Medical R.O.T.C. Estimates construction requirements for training facilities and supervises the preparation of training literature and other training aids.

Hospital Construction Division. Plans and estimates required construction, additions, renovations, and installed equipment for all Army hospitals, including alterations in existing real estate for conversion to hospital purposes. Secures and distributes funds required for maintenance and repair of medical facilities. Plans hospital ships and hospital facilities on transports.

Hospitalization Division. Develops and promulgates policies governing the hospitalization of military personnel. Has administrative supervision of general hospitals, including transfer of patients to these hospitals, and has advisory supervision in the administration of other Army hospitals.

Inspection Division. Coordinates the inspection activities of The Surgeon General's Office and inspection reports from other sources which pertain thereto.

DENTAL SERVICE

Dental Service Division. Prepares administrative regulations for the Dental Service, recommends dental standards for adoption, and rules upon models of teeth submitted in connection with physical examinations. Compiles dental reports and statistical data.

Miscellaneous Division. Classifies dental officer personnel and recommends to the Personnel Service their appropriate assignment and transfer. Recommends selection and distribution of dental equipment and supplies. Prepares training literature for dental personnel and edits the Army Dental Bulletin.

VETERINARY SERVICE

Animal Service Division. Has professional and advisory supervision over matters pertaining to health, efficiency and hospitalization of public animals. Compiles veterinary vital statistics and formulates plans for construction and repair of veterinary hospitals.

Meat & Dairy Hygiene Division. Supervises operation of the Meat & Dairy Hygiene Service of the Army, compiles statistical data thereon, and advises the Federal Specifications Board relative to foods of animal origin.

Miscellaneous Division. Initiates recommendations and maintains reports relative to veterinary personnel. Prepares lists of veterinary equipment and supplies. Prepares veterinary literature for Army publications and reviews scientific articles.

NURSING SERVICE

Nursing Service Division. Formulates policies governing the professional service of the Army Nurse Corps and maintains professional liaison with other nursing organizations. Determines upon standards governing appointment of Army nurses. Administers the mobilization of nurses for overseas units.

Nursing Personnel Division. Controls the procurement, appointment, classification, assignment, transfer and promotion of all nursing personnel. Recommends adoption of Nurses' uniform and equipment.

Approved:

MAJOR GENERAL, U.S. ARMY
THE SURGEON GENERAL
May 9, 1941

CHART VIII

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CHAPTER III

REORGANIZATIONS IN 1942 - 1943

The changes made subsequent to March 1942 indicated that the organization of the Office of The Surgeon General was not entirely complete. Nor did The Surgeon General or higher authority regard the new organization as entirely satisfactory. The organization into services had created more than 40 divisions in the office; the civilian and military personnel functions were still divided between two separate services; and certain single-purpose divisions had been raised to the status of services. Following expressed suggestions from higher authority, the Director of the Control Division began a survey in July of the entire establishment with the idea of consolidating functions still scattered under several responsibilities, to reduce the number of individuals reporting directly to The Surgeon General, to establish some functions not then being adequately cared for, and to improve the flow of work.[1] The study was begun in earnest, but it was never completed. In August The Surgeon General was directed by Headquarters, Services of Supply, to submit a revised plan for reorganization. Lack of time prevented an intensive over-all study of existing organization.[2] Based upon less than one week of additional study, an organization pattern was submitted. The new organization became effective on August 24, 1942,[3] and was later published in the Services of Supply Organization Manual, 1942. From an over-all viewpoint this reorganization was a drastic departure from any previous organization schemes.[4] The number of services was reduced from nine to five, and divisions were decreased from 42 to 23 by reducing a number of divisions to the branch level. A new nomenclature was adopted for the entire organization. Major activities were grouped into services, each under the direction of Chief of Service. Subdivisions on the first level were designated as divisions; second level, branches; and third level, sections. Provision was made for further subdivisions of the sections, but in actual practice the branch constituted the lowest level of organization.[5]

The new plan provided for two divisions on the staff level. The Intelligence Division was removed from the Administrative Service and redesignated as the Public Relations Division on the staff level. The Control Division was continued as a staff division to assist The Surgeon General in carrying out the mission of his office. The specific mission of this division was: "to evaluate the effectiveness with which plans were carried out; to measure the progress of operations under the control of The Surgeon

General, to make recommendations for adjustments in policies, organization and methods...."[6] All other activities were grouped under the five service chiefs, with the exception of the Training and Fiscal Divisions which, as separate operating divisions, answered directly to The Surgeon General. The powers of the Chief of Professional Service were greatly extended. He was made responsible for the over-all supervision and coordination of medical, surgical, preventive medicine, dental, nursing, and veterinary practice throughout the Army. In order to accomplish these increased functions, all professional services were reduced to division level and placed under his direct authority. The old Professional Service was redesignated the Medical Practice Division without material change in function. The Preventive Medicine Service was reduced to the status of a division. In this process the Sanitation Division was divided to become the Sanitation and Sanitary Engineering Branches. The Dental, Nursing, and Veterinary services lost all control over personnel matters and continued to perform the remainder of their duties as divisions of the service.[7]

Important and far-reaching changes took place in the reorganization of the Personnel Service. It now became a complete personnel service in fact as well as in name. In order to assume control over all phases of personnel, the Civilian Personnel Division was transferred from the Administrative Service and completely reorganized along functional lines. The new responsibilities were indicated by establishing the following branches:

Employment
Classification and Wage Administration
Training
Employee Service

At the same time the Military Personnel Division eliminated the reserve functions as no longer necessary and assumed control, including procurement and assignment, of all commissioned, enlisted and nurse personnel.[8]

No change was made in the organization of the Supply Service. That service continued along the pattern adopted on July 1, 1942.

The Administrative Service continued to exercise general supervision over the Office Administration, Vital Records (formerly Vital Statistics), Research and Development, and Historical Divisions.[9] This service now managed and edited the Army Medical Bulletin for the Executive Officer. Activities relating to civilian personnel were transferred to the Personnel Service and the Intelligence Division, redesignated the Public Relations Division, was

ORGANIZATION CHART
SERVICES OF SUPPLY
OFFICE OF THE SURGEON GENERAL

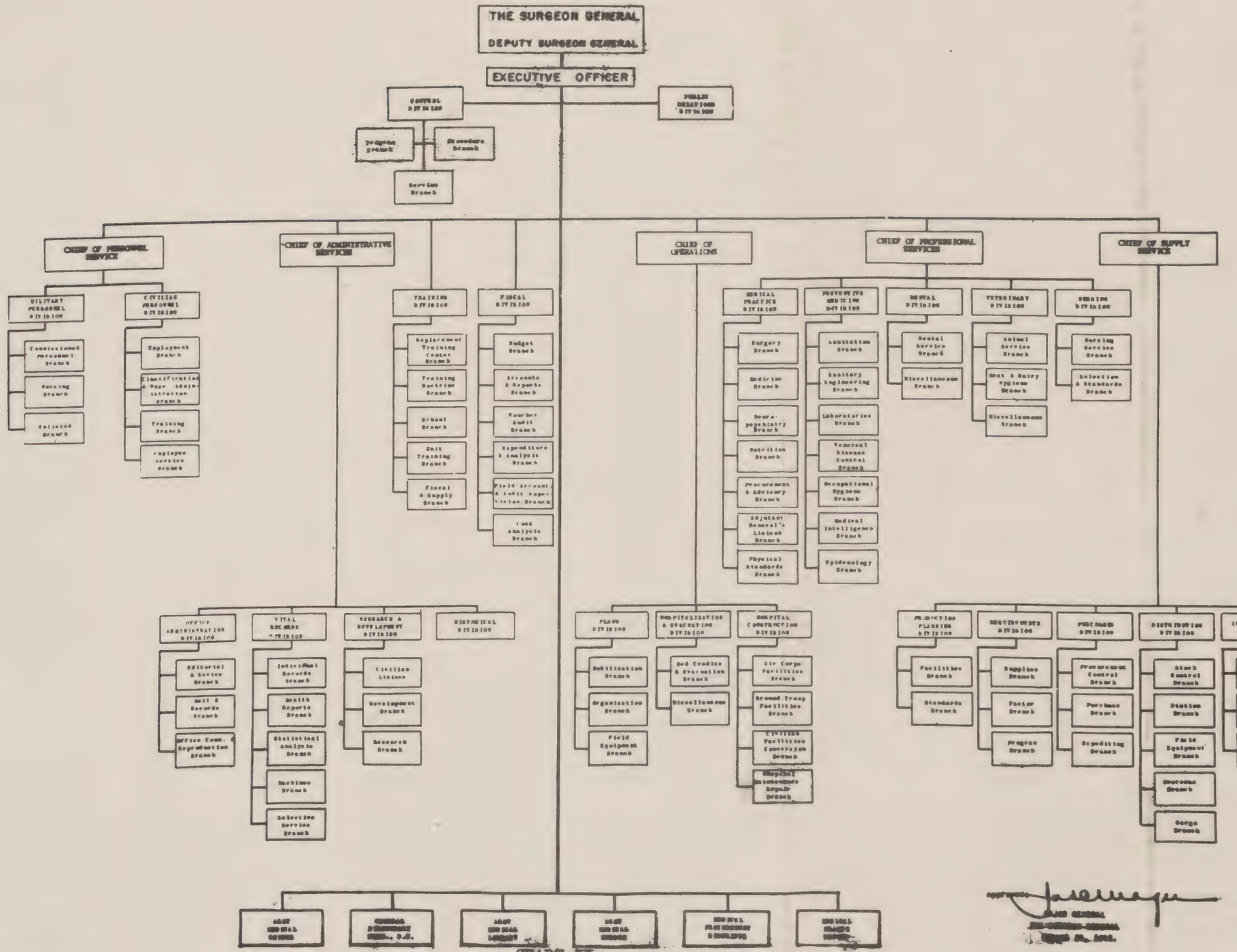


CHART IX

raised to staff level, as stated above.

The August 1942 reorganization relieved the Chief of the Operations Service from control of the Training Division. Inspection activities, formerly the work of a separate division, were distributed to other divisions of the service. The chief continued to coordinate all matters relating to planning, hospitalization, evacuation, and hospital construction. The Plans Division was reconstituted to include the mobilization, organization, and field equipment branches. The Hospitalization Division became the Hospitalization and Evacuation Division. The Bed Credits and Evacuation Branch of this division allotted bed credits, controlled the transfer of patients to named general hospitals, and coordinated the operation plans for hospitalization and evacuation. A new Miscellaneous Branch of the division was created to correlate activities and to carry on the necessary liaison with the Personnel, Supply, and Professional Services.[10]

Two operating divisions in the Office of The Surgeon General were deemed of sufficient specialized importance to merit an organization separate from the services. It will be recalled that the Fiscal Division (formerly the Finance Branch of the Finance and Supply Service) was established as a separate division on July 1, 1942. The two units of its primary organization had developed since that date into six individual branches. The Budget Branch prepared, defended and reviewed all matters relating to appropriations. The Account and Reports Branch prepared all allotments of appropriated funds, reviewed field reports, and kept current the status of all Medical Department funds. The Voucher Audit Branch audited and cleared all items which required periodic payment. The Expenditure Analysis Branch analyzed reports from field installations regarding costs of operations and developed procedures for obtaining supplementary and supporting cost data. Closely allied to the work of this branch, the Cost Analysis Branch acted as the fact-finding unit with respect to prices on all War Department contracts assigned to the Office of The Surgeon General for renegotiation. The Field Accounting and Audit Supervision Branch supervised all fiscal functions in field stations and in field offices; inspected and conducted special audits of field offices; and examined fiscal records for field stations.[11]

The Training Division was also given much needed separate status in the reorganization of August 1942. Since March 1942 it had operated as a subdivision within the Operations Service. This subordinate position was satisfactory so long as The Surgeon General exercised little or no control over the actual training of field units. This had been the situation prior to May 1942, for all field medical units were under the control of the Commanding

General, Army Ground Forces. In May, however, the control of such units became the responsibility of the Commanding General, Services of Supply. This change brought all medical field units under the direct or indirect control of The Surgeon General.[12] He was directly responsible for all numbered medical units at Class IV medical installations. Under authority of the Director of Military Training, ...Services of Supply... and through the Commanding Generals of the Service Commands, The Surgeon General supervised and inspected the technical training of medical units at Class I installations, and at Class IV installations under the control of Chiefs of other branches.[13] In order to supervise this unit training, the Unit Training Branch was created in the Training Division in August 1942. At the same time the other three branches were redesignated as the Replacement Training Branch, the School Branch, and the Training Doctrine Branch, designations which were maintained until May 1944.[14] With the redesignation of the branches, the Training Division was allotted 14 officers and assigned the following specific duties:

> To coordinate all training policies, plans, and activities of the Medical Department;
>
> To establish policies, formulate plans, supervise, and coordinate training in medical replacement training centers, special service and enlisted technicians schools, Medical Administrative Corps Officer Candidate schools, Medical Department pools and organized medical units assigned or attached to Army Service Forces in unit training centers of the Medical Department;
>
> To establish policies, formulate plans, supervise, direct and coordinate training of medical personnel in civilian and vocational institutions and in industries;
>
> To prepare estimates for instruction and maintenance of appropriate schools and replacement training centers, and coordinate the suballotment and expenditures of training funds allocated to the Medical Department;
>
> To establish policies, formulate plans, and coordinate training in Medical ROTC, Officer Reserve Corps, and organized Reserves of medical units assigned or attached to Army Service Forces;
>
> To initiate, develop, direct, and coordinate training doctrine for all types of medical units;

To allocate quotas to medical units and installations of the Army Ground Forces, Army Air Forces, and Army Service Forces, and direct training of quotas in various schools, conduct training inspections of schools, replacement training centers, officer candidate schools, unit training centers, and medical units of the Army Service Forces; and

To recommend and coordinate the assignment to medical units of all unassigned graduates of enlisted technicians schools.[15]

Complaint was made that the "restrictive ceilings in personnel, the reorganization of the Army into three distinct echelons and decentralization of control and authority along with decentralization of execution, have not facilitated the ability of The Surgeon General or the Training Division to discharge assigned functions or responsibilities."[16]

The organization of August 1942 successfully reduced the number of divisions reporting directly to The Surgeon General. It carried out the fundamental principle of decentralization of authority, yet allowed for a functional grouping of activities. It clarified the duties assigned to subordinate units. This major reorganization established the pattern for office organization during the war years.

The reorganization consummated in August 1942 continued, with two exceptions on the staff level, until the spring of 1943. In September 1942 the War Department changed its policies with regard to the handling of military information and directed that each agency "operating in the field of public relations ... be known as an Office of Technical Information."[17] The Public Relations Division subsequently was renamed the office of Technical Information and continued to operate without change in function.[18] For no apparent reason it was soon reduced from the status of a staff division to that of a branch in the Office Administration Division.[19] It continued on branch level until April 1943 when it was again restored to staff level as the Office of Technical Information.[20]

A second and more important change on the staff level was the creation of a Legal Division. The necessity for a group of legal specialists in the Office of The Surgeon General had long been recognized. A small legal staff had been acquired to assist the Chief of the Supply Service. Although it was decided to increase the functions of this staff and to insure its services to all divisions of the office, the functions of the newly created Legal Division

dealt largely with supply matters.[21] The division was to serve as legal advisor to The Surgeon General; act as general counsel for the New York and St. Louis Medical Procurement Districts and other contracting officers; supervise contracts and bids; draft procurement directives; and act as counsel in cases of price adjustments of renegotiated contracts. The division served in an advisory capacity on all matters concerning statutes, regulations, and directives from higher authority.[22]

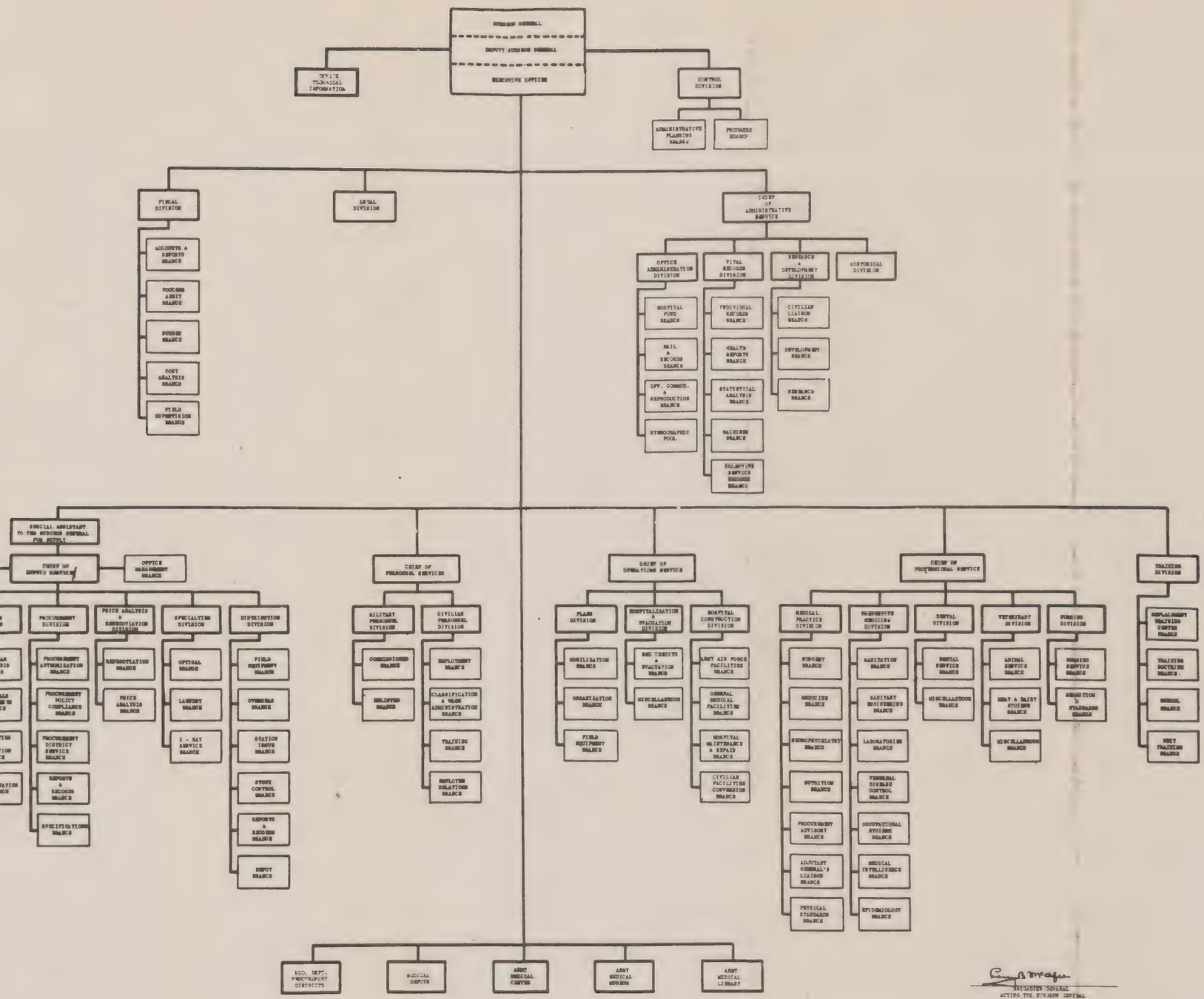
Throughout the summer and fall of 1942 the operations of The Surgeon General's Office were subjected to searching inquiry by a committee appointed for that purpose by the Secretary of War. One of the many questions raised by the committee concerned the effectiveness of the operation of the Supply Service. One basic recommendation of the committee was, "that non-medical men of appropriate training and experience be placed in key positions in the Supply Service, Procurement Districts, and Supply Depots and commissioned with sufficient rank ..."[23] The Surgeon General, fortunately, had foreseen this necessity and had on 13 November 1942" ... engaged the services of a special civilian assistant for the purpose of aiding in more adequate operation of the Supply Service."[24] Intensive study of supply operations by the special civilian assistant over a period of months led to recommendations for the reorganization of the service.

On 26 February 1943 the Supply Service was reorganized "and the duties of the various divisions distributed into smaller groups of activities which were closely related."[25] In the rearrangement of the service, an Assistant Chief of the Supply Service was empowered to act as coordinator. A Materiel Office, reporting directly to the Chief, coordinated procurement and scheduling activities among the divisions. The remainder of the service was organized into two separate branches on the staff level (Supply Personnel and Office Management) and seven divisions, as follows: Requirements, International, Resources, Procurement (formerly Purchases), Price Analysis and Renegotiation (formerly Price Adjustment), Specialties, and Distribution.

Some of these divisions were new and require, at this point, a few words of explanation.[26]

The Resources Division devoted its attention to alleviating the raw material shortage which, during this period, was hampering the production of medical supplies and equipment. To accomplish this purpose, it was divided into four branches: Program Analysis, Materials Requirements, Priorities and Allocation, and Conservation.

The Price Analysis and Renegotiation Division was established to analyze contract prices submitted by manufacturers



BRIGADIER GENERAL
ACTING THE SURGEON GENERAL
APRIL 1, 1943

CHART X

and to carry out the terms of the renegotiation statutes which had been enacted by Congress in 1942 and 1943. The division was formed by joining the functions of the old Price Adjustment Division, Supply Service, and the Cost Analysis Branch of the Fiscal Division.

The Specialties Division, which included an Optical Branch, Laundry Branch, and X-Ray Service Branch, was not an operating division. Rather, its function was to study the peculiar problems encountered in the procurement and distribution of certain specialized items and to make this information available to the other divisions. It had administrative and coordinating functions almost entirely.

Although there were many alterations within each division, the functions of the other divisions remained substantially unchanged.

On 5 May 1943, further changes were made. A Storage and Maintenance Division was established, which embraced the functions of the Depot Branch of the Distribution Division and the packing and crating activities of the Office of the Assistant Chief.[27]

The organizational changes made in the spring of 1943 brought to an end a year of successive attempts to organize the Office of The Surgeon General on a functional basis. The basic reorganization under the Army Service Forces had been modified to meet the increased demands placed upon The Surgeon General. No further changes were indicated.

NOTES FOR CHAPTER III

[1]SGO Control Division Procedure Assignment 5, July 22, 1942, in file of Director, Control Division, SGO.

[2]Ibid., also Procedure Assignment 15, Aug 19, 1942.

[3]Ibid., Services of Supply Organization Manual published Sep 30, 1942; SGO Office Order 340, Sep 1, 1942.

[4]Organization Chart, SOS, Office of The Surgeon General, approved Aug 24, 1942; Chart IX, this study.

[5]SGO Office Order 340, par 2, Sep 1, 1942.

[6]Ibid., SGO, Office Order 372, Sep 23, 1942.

[7]SGO Office Order 340, Sep 2, 1942.

[8]Ibid.

[9]Ibid.

[10]Annual Report of Operations Service, 1943 (Historical Division, SGO, 319.1-2).

[11]Services of Supply Organization Manual, Sep 2, 1942, p. 304.07/4.

[12]Annual Report of the Operations Service, 1942-43, p. 30 (Historical Division, SGO, 319.1-2).

[13]Ibid., p. 33.

[14]Ibid., pp. 3-4; Memorandum for Historian, Operations Service, SGO, from Director, Training Division, Subject: History of Operations Service. Jun 30, 1944 (Historical Division, SGO, 314.7-1).

[15]Ibid., pp. 3-4.

[16]Ibid., p. 4.

[17]WD TAGO Memorandum No W 600-13-42, Sep 21, 1942, Subject: Reorganization of Public Relations Agencies (SGO Record Room 020.4-1).

[18]SGO Office Order 396, Oct 13, 1942.

[19]SGO Office Order 441, Nov 2, 1942.

[20]Memorandum for the Historical Division, SGO, Subject: Annual Report of Control Division, Jul 16, 1943 (Historical Division, SGO, 024.-8).

[21]Ibid., p. 2; SGO, Fiscal Year Report to CG, SOS, 1942, p. 28 (Historical Division, SGO, 319.-1).

[22]SGO Office Order 496, Nov 30, 1942.

[23]Memorandum from the Commanding General, Services of Supply, to The Surgeon General, Nov 26, 1942 - Recommendation 76, Copy included in "Report of The Wadhams Committee" (Historical Division, SGO).

[24]Annual Report of the Control Division, SGO, 1943, p. 2 (Historical Division, SGO 024.-8).

[25]Ibid., p. 4.

[26]Yates, Richard E., The Procurement and Distribution of Medical Supplies in the Zone of the Interior during World War II, p. 58 (Historical Division, SGO); Chart X.

[27]Annual Report of the Control Division, SGO, 1943, p. 4 (Historical Division, SGO 024.-8).

CHAPTER IV

REORGANIZATION UNDER THE NEW SURGEON GENERAL

On 1 June 1943 Major General Norman T. Kirk became The Surgeon General. The new head of the Medical Department found himself confronted by a serious dilemma. He inherited an office which had seriously exceeded its officer allotment; yet he acutely needed additional officers in professional divisions to supervise new activities, such as the reconditioning of soldier-patients.[1] With characteristic vigor, he attacked the problem of setting his new official house in order. Within 15 days after assuming command he promulgated sweeping changes in the organization of the office which provided for the grouping of functional activities. All separate divisions, with the exception of two remaining at staff level, were placed under control of the five services. The Legal Division and the Fiscal Division thus became part of the Administrative Service; and the Training Division, with no change in internal organization, was placed under the supervision of the Chief of the Operations Service. The Research and Development Division, formerly a part of the Administrative Service, was reduced to branch level and became part of the Plans Division, Operations Service.

To meet the increased demands placed upon the office, The Surgeon General established two new divisions in the Professional Service. The Surgical Branch of the Medical Practice Division became the Surgical Division, with its functions divided among three branches. The Surgery Branch retained all the duties of the old branch. In addition it afforded consultation and advice on all matters pertaining to surgery and assisted in the identification and proper allocation of specialists. The Radiation Branch and the Physical Therapy Branch were created to provide similar facilities in their respective areas. A Reconditioning Division was organized for the purpose of studying and planning policies relating to the rehabilitation and convalescence of patients who no longer needed ward care, but who were not able to return to active duty. To carry out the mission of the new division the War Exhaustion, Physical Reconditioning, and Occupational Therapy Branches were established. Since all surgical activities had been transferred from it, the name of the Medical Practice Division was changed to Medical Division.[2] The new plan also provided that nationally known specialists in the various fields of medicine would be appointed as consultants to The Surgeon General and to the Chief of the Service.

As a general efficiency measure and also to free the officer allotment for the professional purposes mentioned

above, The Surgeon General and his advisors made extensive changes in the organization of the Supply Service. This service was one of the largest in the office. At the beginning of June 1943 it consisted of 114 officers and 524 civilians. An intensive study was made by the Control Division and the newly appointed Acting Chief of the Supply Service, with the hope of reducing the number of officer and civilian personnel.[3] The first step taken in the process of reorganization reduced the service overhead by eliminating all such posts except the Chief of the Service and an executive officer. In the next step the Office Management Branch was transferred to the Control Division and the Supply Personnel Branch was assigned to the Military Personnel Division. The remainder of the service was then reshuffled. In this process the Office of Assistant Chief, the Materiel Office, the Resources Division and the Specialties Division were abolished, and a large portion of their activities were reduced or regrouped. The Requirements and the Distribution Divisions were merged to form the Distribution and Requirements Division, composed of the Storage, Issue, Requirements, Stock Control, and Maintenance Branches. The five branches of the Procurement Division were consolidated into the Purchases and Production Branches. The International Division was unchanged, except that the Coordination and Analysis Branch became the Analysis Branch. The name of the Price Analysis and Renegotiation Division was simplified to Renegotiation Division. A new Supply Planning and Specialties Division assumed most of the service overhead in the Catalogue and Equipment List, Machine Records, Reports, and Specialties Branches.[4] With these changes the service was consolidated into a more closely knit organization composed of five divisions, and the personnel was reduced to 83 officers and 452 civilians. This major saving in personnel provided the needed openings for specialists in the professional divisions and helped to bring the office within its authorized allotment.[5]

The structure of the Personnel Service was thoroughly revised. The duties of the Commissioned Branch, Military Personnel Division, were segmented and reassigned to four separate branches. The Procurement Branch processed all applications for appointment of commissioned personnel in all corps of the Medical Department. The Classification Branch examined all data concerning the civilian background of officers and placed officers in their proper professional assignments, maintained all the files relating to the classification specialties of officers, and recommended qualified officers for specialized assignments. An Operations Branch issued travel orders for personnel under the control of The Surgeon General, recommended assignments of personnel to The Adjutant General in order to fill vacancies in new units or task forces, and controlled the promotion of officers under the authority of The Surgeon General. A Records Branch maintained the personnel cards and

files for all Medical Department officers. The Enlisted Branch continued to exercise administrative control over the warrant officers and enlisted men of the Medical Department and to make recommendations regarding the allotment of enlisted personnel for stations and units.[6] Few changes were made in the civilian Personnel Division. It will be recalled that this division had been thoroughly reorganized in April.[7] The Employment Branch, however, was divided into two parts. The Recruitment and Placement Branch continued to carry on most of the functions of the old branch but surrendered to the Status, Payroll and Records Branch all processing of personnel papers, preparing payrolls, maintenance of personnel records, and the preparation of all personnel reports.[8]

In addition to acquiring the Research Coordination Branch, as noted above, the Plans Division of the Operations Service was subjected to further important changes. It was divided into six branches, three of which had been recast from old ones. The Mobilization and Overseas Operations Branch continued the functions of the old Mobilization Branch but added the "planning for the mobilization of all types of Medical Department units."[9] The Organization Branch became the Organization and Equipment Allowance Branch, and assumed those functions of the Field Equipment Branch which included the preparation of Medical Department Tables of Allowances, Tables of Basic Allowances, and Tables of Organization and Equipment. In addition, it reviewed the medical sections of Tables of Organization and Equipment of other arms and services. The Field Equipment Branch was reconstituted to supervise and develop new and existing field equipment; to represent The Surgeon General on the technical committees of other arms and services; and to review the specifications for field equipment prepared by the Supply Service.

Three new branches were designated within the Plans Division. The change in status of the Research Coordination Branch did not change its functions. It continued to be responsible for coordinating the administrative details of the Medical Department agencies concerned with research and development projects, with liaison to government and civilian research agencies, and with the administrative and clerical duties of the Medical Department Technical Committee. The Inspection Branch was reconstituted to coordinate inspections conducted by officers from all services of The Surgeon General's Office and the inspection activities of the service commands relating to professional treatment, training, hospital administration, hospital facilities, and sanitation. All other planning activities were placed under a Plans Coordinations Branch. These included periodic plans involving medical service for occupied areas and medical problems incident to demobilization.

Other divisions of the Operations Service were little changed. The Hospital Construction Division was continued with no stated alteration in functions. A minor rearrangement was made in the Hospitalization and Evacuation Division, which divided it into the Hospital Policies Branch and the Evacuation Branch. The former assumed most of the duties of the old Miscellaneous Branch, correlated all activities, made inspections of hospital administrative functions, and recommended measures to conserve manpower in the treatment of patients. The latter performed all the duties of the former Bed Credits and Evacuation Branch and added liaison with the Chief of Transportation in order to coordinate the medical and sanitary activities in Ports of Embarkation and the medical service on transports and hospital ships.[10]

Only one division in the Administrative Service remained untouched by the new scheme of organization: namely, the Historical Division.

As noted before, the Research and Development Division had been deleted and the Legal and Fiscal Divisions added to the Administrative Service. No change in function was indicated in either case. The Vital Records Division was renamed the Medical Statistics Division and continued to operate without modification in actual organization. The Office Administration Division became the Office Service Division. Three branches of this division were little changed. The Mail and Records Branch was charged with providing internal security for classified materials in addition to its other duties; the Hospital Fund Branch ceased to approve applications for admission of pay patients to the Army and Navy General Hospital; and minor changes were made when the Office Commodities and Reproduction Branch became the Office Commodities Branch. The stenographic pool was assigned to a new General Service Branch. This branch also edited requisitions for utilities, assigned office space, and performed other general service functions. A Publications Branch was established to review proposed SGO directives and orders for content and form, maintain distribution lists, edit manuscripts for publication, analyze incoming informational material, and to edit and manage The Army Medical Bulletin.

The organization chart implementing the above changes was approved by The Surgeon General and published on 15 June 1943.[11] He then forwarded the chart to the Commanding General, Army Service Forces, for "consideration and approval."[12] The Commanding General approved the proposal as a working organization for the immediate future, but "desired that consideration be given to . . . further simplication of the organization by:

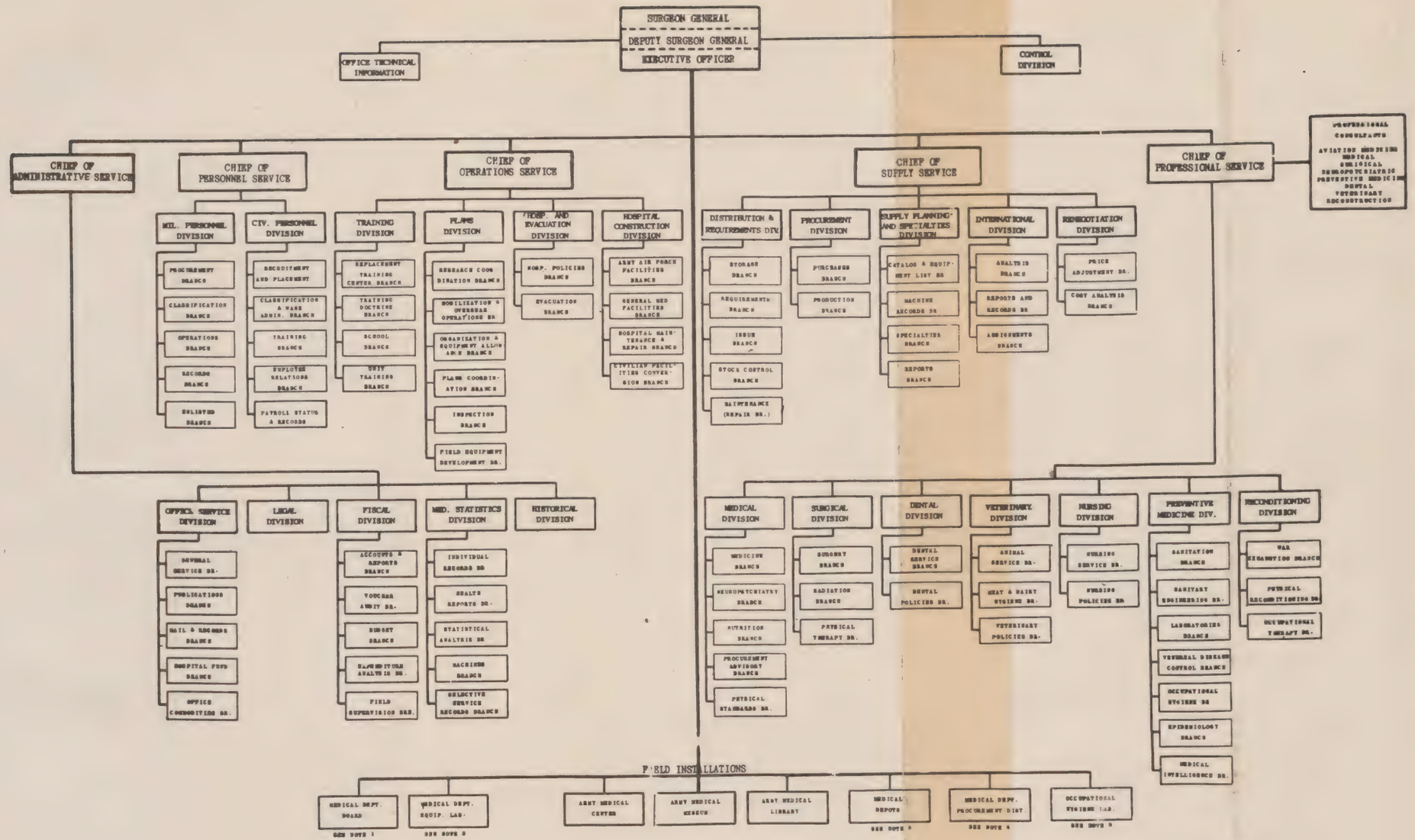
Combining Issue Branch and Stock Control Branch;
Combining Price Adjustment and Cost Analysis Branches with the Purchases Branch;
Combining the Requirements Branch with the Supply Planning and Specialties Division;
Placing the Research and Development Branch under the Chief of Supply Service; and
Combining of the Hospital Construction Division and the Hospital and Evacuation Division."[13]

The Surgeon General, after careful consideration, submitted a defense of the proposed supply organization in which the first four points had been raised.[14] On the first proposal, he pointed out that:

> The Stock Control Branch performs the function of distribution of material as furnished by manufacturers, and also by effecting inter-depot transfers when necessary. Constant effort is made to minimize inter-depot transfers to avoid cross hauling. The function of the Stock Control Branch really falls under the classification that has now been designated by Headquarters, A.S.F., as "Inventory Control." The Issue Branch is concerned with the issuing of medical supplies and equipment to stations in the Zone of Interior, to tactical units in this country, and to overseas bases. The functions of the two branches are entirely distinctive and are not susceptible of amalgamation. . . . The present Stock Control Branch should be redesignated the Inventory Control Branch.[15]

In addressing himself to the second proposition, The Surgeon General stated:

> The Price Adjustment Branch and the Cost Analysis Branch constitute the whole of the Renegotiation Division. The question of combining this with the Procurement Division has been considered carefully both in setting up the present organization of the Supply Service and also in the last previous organization, and has been reconsidered in the light of your inquiry. The reasons governing the decision still seem controlling: namely, that the renegotiation function is a reconsideration of what the contract price should be after review of the manufacturer's operation and experience, thereby involving factors frequently not available to the contracting officer at the time the contract was originally



NOTE 1 - MED. DEPT. BD. REPORTS DIRECTLY TO PLANS DIV., OPERATIONS SERVICE.
NOTE 2 - MED. DEPT. EQUIP. LAB. REPORTS DIRECTLY TO RESEARCH & DEV. BR., PLANS DIV., OPERATIONS SERVICE.
NOTE 3 - MED. DEPOTS REPORT DIRECTLY TO DISTRIBUTION DIV. SUPPLY SERVICE.
NOTE 4 - MED. DEPT. PROC. DISTS. REPORT DIRECTLY TO PROCUREMENT DIV., SUPPLY SERVICE.
NOTE 5 - OCCUPATIONAL HYG. LAB., REPORTS DIRECTLY TO OCCUPATIONAL HYG. BR., PREVENTIVE MED. DIV., PROF. SERV.

CHART XI

W. D. Kirk
MAJOR GENERAL, U. S. ARMY
THE SURGEON GENERAL
JUNE 15, 1943.

entered into. Particularly the cost analysis function is not one performed by the Purchases Division and the procurement officer. The relationship is much the same as that of an auditor to the accountant whose work he reviews. It is believed fundamental that these two functions should not report to the same divisional authority.[16]

His third point sought to explain why it would be impracticable to combine the Requirements Branch with the Supply Planning and Specialties Division:

> The Requirements Branch was formerly an independent division of the Supply Service but in the recent reorganization was made a branch of Distribution and Requirements Division. A principal function of this Branch is the computation of the Army Supply Program, which is a long-range procurement plan with the required quantities listed by calendar years only. For some months the Supply Service has been considerably confused by the fact that this long-range program was not properly coordinated with the comparatively short-term needs for issue and for assembly of unit equipment. These needs had to be computed by the Distribution Division for its operations. With the inclusion of Requirements Branch in the Distribution Division, this computation of short-term needs and the correlation of it with the longer range planning in the Army Supply Program is assigned to the Requirements Branch. A second important function of the Requirements Branch is the policing of maintenance rates used in computing the Army Supply Program, for which a closer connection with the depot issue rates had proven desirable. In the short space of a month, the desirability of inclusion of Requirements Branch in Distribution Division has been proved conclusively to the officers directly concerned.
>
> The planning function of the Supply Planning and Specialties Division is quite different from the function of computing the Army Supply Program. It involves a great deal of coordination and liaison with other services in the Surgeon General's Office; particularly various divisions and branches of the Professional Service, representation on the Technical Committee and other such groups concerned with the determination of standard Medical Department items. Based on the information thus obtained, this division plans the Supply Service activity

necessary to carry into effect the procurement and issue of the items decided upon. A concrete example is the recent decision to supply dyed bandages and dressings in theaters of operations. Carrying this into effect involves foresighted planning of a great many detailed steps. The work of the Supply Planning and Specialties Division in such cases is proving very beneficial to the operations of the Supply Service.[17]

The fourth suggestion, that of placing the Research and Development Branch under the Chief of Supply Service, was dealt with at some length:

> The Research Coordination Branch (formerly the Research and Development Division) does not correspond in function to the research and development branches or sections of other technical services. It exercises no control or authority over the actual execution of research and development projects. It is essentially the coordinating agency for administrative details of the Medical Department research program, including consolidation of research estimates and progress reports, correspondence with Headquarters, Army Service Forces, and execution of essential steps in each research project including the standardization of any newly developed items or the reclassification of existing items. It carries on all the clerical and administrative activities of the Medical Department Technical Committee. It acts in a liaison capacity with various civilian and federal agencies on research matters. In short, the Research Coordination Branch is administrative in nature rather than technical.
>
> The wide range of responsibilities and activities of the Medical Department necessitates the assignment of professional and technical functions to several different divisions, each handling activities within a limited field. Thus the Medical and Surgical Divisions are responsible for all therapeutic measures, the Preventive Medicine Division for preventive measures, the Veterinary Division for veterinary service, the Dental Division for dental service, and the Plans Division for the organization and field equipment in addition to the other functions implied by its title. Each of these divisions is responsible not only for the administrative handling of matters within its field of activities but also for the advancement of technical knowledge, supplies, equipment and methods applicable to these activities.

> Therefore, the responsibility for the technical and professional aspects of research and development is assigned in part to each of several divisions according to the research or development project in question. . . The transfer of the Research Coordination Branch to the Supply Service would be justified only in the event that it was desired to separate developmental projects from those of fundamental professional research. In that event there might be a development branch or division in the Supply Service and a research division or branch in the Professional Service. This immediately would present the need for the establishment of some central branch or division to consolidate the fiscal activities, progress reports and other administrative details incident to the operation of these two divisions or branches. The Research Coordination Branch fulfills this latter requirement as now organized.[18]

The final suggestion made by the Commanding General, Army Service Forces, concerned combining hospitalization, evacuation, and hospital construction functions of the office. This suggestion was accepted by The Surgeon General, who proposed that all administrative functions relating to hospitals be brought together under a Hospital Administration Division. At the same time he pointed out that the control of professional hospital policies would not be included in the new division. He further proposed to establish the following branches and functions:

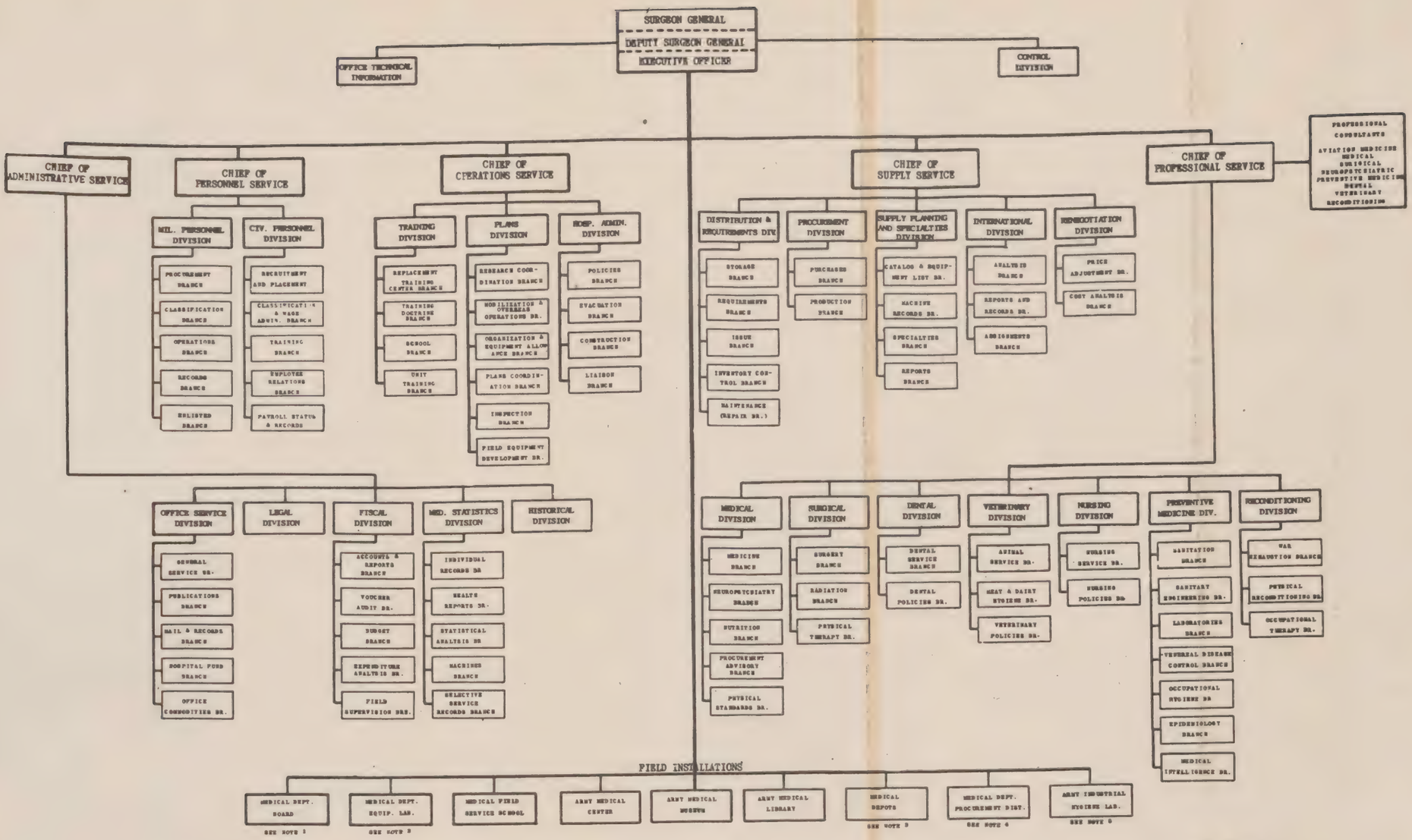
> The Evacuation Branch to establish bed credits and coordinate the evacuation of patients;
> A Policies Branch to establish and promulgate hospital administrative policies;
> The Construction Branch charged with all hospital construction activities; and
> A Liaison Branch to provide for important liaison activities with the Transportation Corps in the coordination of movement of hospital trains and the technical supervision of medical service at ports and staging areas; with the WAC Headquarters for all phases of medical service relating to women in the Army; and with the Provost Marshal General for medical service to prisoners of war.[19]

The Commanding General, Army Service Forces, agreed to all proposals set forth by The Surgeon General.[20] A new organization chart of the Office of The Surgeon General was then published incorporating the changes in the Hospital Administration

Division.[21] Liaison officers were placed on duty with the Transportation Corps and with the Women's Army Corps; and a Prisoner of War Liaison Unit was instituted in the Office of The Provost Marshal General. The Liaison Branch was further designated as "the central office for all medical matters pertaining to these agencies" through the Operations Service.[22] An office order confirmed the changes and established detailed functional descriptions of the entire office and its component parts.[23]

The modus operandi set forth at this time was not regarded as the final solution to The Surgeon General's problems of office organization. The very speed with which the new plan was evolved glossed over some areas still badly in need of reform. The situation was not improved by the announced intention of the Army Service Forces to reduce the ceiling on civilian personnel in the office.[24] In an effort to meet the proposed reductions without the sacrifice of essential work and to increase the efficiency of the Office of The Surgeon General, representatives of the Control Division commenced intensive study of the Fiscal Division during July 1943.[25] The division at this time consisted of the Budget, Accounts and Reports, Expenditure Analysis, Voucher Audit, and Field Supervision Branches. The analysis made by the Control Division of the functions of these branches disclosed that the work of the Voucher Audit Branch consisted, in the main, of auditing vouchers which could be more efficiently audited in the field. It showed further that the Expenditure Analysis Branch analyzed and prepared reports regarding cost of operations which were primarily used as supporting data for the Budget Branch. The investigators believed that most of these activities could be eliminated and that all essential work could be performed without loss of efficiency by the Budget Branch or by the Accounts and Reports Branch. These conclusions were agreed to by the Director of the Fiscal Division, and the Voucher Audit and Expenditure Analysis Branches were eliminated. No change was made in the operation of the Field Supervision Branch.[26] As a direct result of these readjustments, the number of officers in the division was reduced from 11 to 8, and 27 of the 78 civilian employees were released for other duty.[27]

The search for ways to improve the utilization of personnel and equipment led to further changes. Both the Statistics Division and the Supply Service had long maintained separate branches for the production and processing of machine records. Close examination of the type of work done in each branch disclosed a wasteful duplication of effort which would be eliminated if the two branches were



NOTE 1 - MED. DEPT. BD REPORTS DIRECTLY TO PLANS DIV., OPERATIONS SERVICE.
NOTE 2 - MED. DEPT. EQUIP. LAB. REPORTS DIRECTLY TO RESEARCH COOR. BR., PLANS DIV., OPERATIONS SERVICE.
NOTE 3 - MED. DEPOTS REPORT DIRECTLY TO DISTRIBUTION & REQUIREMENTS DIV., SPLY. SER.
NOTE 4 - MED. DEPT. PROC. DISTS. REPORT DIRECTLY TO PROCUREMENT DIV., SUPPLY SER.
NOTE 5 - ARMY INDUSTRIAL HYG. LAB. REPORTS DIRECTLY TO OCCUPATIONAL HYG. BR., PREVENTIVE MED. DIV., PROF. SERV.

CHART XII

M. C. Kirk
MAJOR GENERAL, U. S. ARMY
THE SURGEON GENERAL
JULY 10, 1943.

merged into a single machine records unit. The separate branches were then abolished and a Machine Records Branch was created in the Office Service Division during August 1943. The new branch continued all the essential functions of the old branches; they punched, sorted, and tabulated cards from Selective Service reports; computed the Army Supply Program; and prepared the Consolidated Stock Report and other stock control reports.[28]

The trend towards simplification in the Supply Service was carried a step further in September 1943, when the Supply Planning and Specialties Division was abolished. The Reports Branch of the division was transferred to the Chief of the Supply Service, and the remaining activities were assigned to the Procurement Division.[29] Within two months, however, further reorganization within the Supply Service reinstated the old Supply Planning and Specialties Division as the Supply Planning Division with expanded functions. In addition to its administrative and coordinating duties for special programs not following routine channels, this division had the responsibility of preparing and distributing the Medical Department Supply Catalogue and Equipment Lists and with aiding in the development of new items.[30]

The reorganization of the Supply Service in November 1943 moved the greater portion of stock control activity to New York City. This important change had been recommended by the Director of the Control Division and the Acting Chief of the Supply Service.[31] Movement was facilitated by the reorganization of the Medical Department Procurement Districts which had taken place in September 1943. At that time the New York Medical Department Procurement District was redesignated as The Army Medical Purchasing Office with branches in St. Louis and Chicago, and the St. Louis Medical Department District was abolished. The terms of the directive which created the new organization held it "responsible for the actual procurement of medical supplies, including production control, issuance of priorities, survey of facilities, and inspection of supplies."[32] To effect the transfer of most stock control activities, the Inventory Control Branch of the Distribution and Requirements Division was attached, and the Procurement Division (renamed the Purchase Division) was transferred to the Army Medical Purchasing Office. A small Liaison Branch of the Purchase Division was established in the Supply Service in Washington, which maintained close contacts with the parent unit and performed certain functions relating to procurement. At the same time, those activities of the Reports Branch which had been assumed by the Chief of the Service in September were established in a staff unit known as the Reports and Records Branch. This branch prepared reports required by higher authority on the progress of procurement and distribution activities.[33]

The consolidation of the New York and St. Louis Medical Department Procurement Districts and the increase in number and amount of Medical Department contract terminations led to the reorganization of the Legal Division, SGO. This was accompanied by the establishment of the Legal Division, Army Medical Purchasing Office, in October 1943 to care for legal matters related to procurement. The Legal Division, SGO, continued to act as general counsel to The Surgeon General, furnished counsel on procurement matters required in the Office of The Surgeon General, and maintained liaison activities for legal matters with the Army Service Forces and with The Judge Advocate General's Department. The directors of both Legal Divisions were authorized to coordinate when necessary on procurement matters.[34]

The reorganizations made within the Office of The Surgeon General during the first six months of the new Surgeon General's incumbency led to greater efficiency in supply and fiscal operations and secured a more effective utilization of the personnel so engaged. During this period, two special units aided The Surgeon General in accomplishing these results. The first of these was a board of officers to formulate subprograms within the War Department general program for the more effective utilization of personnel.[35] A continuing need for this board was demonstrated; and, as a result, the board was reconstituted in October to include the Deputy Surgeon General, the Executive Officer, the Acting Chief of the Supply Service, the Chief of the Personnel Service, and the Directors of the Control, Civilian Personnel and Fiscal Divisions.[36] In addition, the over-all management of personnel during this period was vested in a Personnel Requirements Board which controlled the allotment and distribution of personnel to the divisions. At the direction of Headquarters, Army Service Forces, this Board was made to conform to the prescribed pattern for such units in other technical services, and became the Personnel Control Unit for the Office of The Surgeon General in October 1943.[37]

While the major effort of The Surgeon General during his first few months in office was devoted to securing greater efficiency in management, efforts were made to provide for the military and professional development of Medical Department officers. In August 1943 The Surgeon General announced his intention to sponsor a series of professional meetings "to foster closer social and professional relations" among Medical Department officers stationed in Washington and vicinity.[38] These meetings, held monthly during the war years, provided a means by which experts in the various fields of medicine, together with those who had occupied important foreign or domestic assignments, could impart their experience to headquarters officers. It was evident, however, that monthly meetings would

make it possible for only a few of the many experts to appear, and it was believed necessary to recapture the experiences of many other officers in interviews. A procedure for conducting interviews was established, and the Inspection Branch of the Operations Service was made the central agency to interview, coordinate, and publish reports of the interviews within the Office of The Surgeon General.[39]

Additional steps were taken to disseminate military information to all Medical Department officers and to the public. The procedure for handling professional manuscripts which were submitted for review by Medical Department officers was changed. Until September 1943 all such manuscripts, before publication, had been submitted to and reviewed by a board of officers established for that purpose in the Office of The Surgeon General. This procedure had proved unwieldy and slow. Manuscripts, henceforth, would be submitted directly to the Office of Technical Information, SGO, for clearance in security matters and then referred to the appropriate divisions for rapid review.[40] The new procedure greatly expedited the process of getting manuscripts into the hands of the publishers. A far more important development was the decision to change the Army Medical Bulletin to a monthly publication. The new publication, known as The Bulletin of the U.S. Army Medical Department, absorbed the quarterly dental and veterinary bulletins and was intended to be educational rather than directive in nature. "Dedicated to keeping the personnel of the Medical Department informed on developments in war medicine", it promised to "contain the best information obtainable concerning military medical experience, observations, and procedure . . . to help further the quality of professional services." The management of the new publication was temporarily assigned to the Medical Intelligence Branch of the Preventive Medicine Division, Professional Service.[41]

NOTES FOR CHAPTER IV

[1] Inclosure 1 to Memorandum from Acting Director, Control Division, SGO, to Director, Control Division, ASF, no subject, 23 Aug 1943 (Record Room, SGO, SPMC 024.-1).

[2] Ibid., ASF Organization Manual, 15 Jul 1943, pp. 306.00. 11,13

[3] These two agencies bore the brunt of the investigation, although provisions for such studies had been ordained by higher authority twice in the previous six months. A five-man Personnel Requirements Board, having as its purpose the control of allotment and distribution of both military and civilian employees, had been established December 1942 by Office Order 515 (1942). A second board to formulate subprograms for the more effective utilization of personnel had been organized in March 1943 with the following objectives:

a. To develop and utilize adequate personnel data;
b. To establish an effective control over numbers of personnel;
c. To replace certain types of personnel;
d. To expand, refine, and speed up present plan of personnel management;
e. To eliminate all nonessential activities;
f. To improve organizational structure;
g. To decentralize activities and authority to act to greatest extent possible; and
h. To increase the efficiency with which essential activities are performed.

The Control Division was designated as The Surgeon General's agency to coordinate the action of the latter board in cooperation with all other personnel. See Memorandum from Chief of Staff, ASF, for the Commanding Generals of Supply and Administrative Services . . . , subject: Program for the more effective utilization of personnel, 1 Mar 1943 (Historical Division, SGO, 230.-1); SGO Office Order 109, 3 Mar 1943; Memorandum from The Surgeon General to all officers, SGO, 13 Mar 1943 (Historical Division).

[4] Annual Report of the Control Division, SGO, to the Historical Division, SGO, 10 Jun 1943, p. 5 (Historical Division, SGO, 024.-8).

[5] Memo to Director, Control Division, ASF, 23 Aug 1943, cited above, Note 1.

[6] ASF Organization Manual (301), 15 Jul 1943, p. 306.00. 4-5

[7]See SGO Organization Chart, approved 1 Apr 1943; Chart X of this study.

[8]ASF Organization Manual, 15 Jul 1943, p. 306.00 6.

[9]Ibid., p. 306.00 7.

[10]Ibid., p. 306.00 7-8.

[11]SGO Organization Chart, approved 15 Jun 1943; Chart XI of this study.

[12]Memorandum from The Surgeon General General for the Commanding General, ASF, subject: Organization of Surgeon General's Office, 18 Jun 1943 (Record Room, SGO, 024.-1).

[13]Ibid., 1st Indorsement, 1 Jul 1943.

[14]Ibid., 2nd Indorsement, 7 Jul 1943.

[15]Ibid., par 1a.

[16]Ibid., par 1b.

[17]Ibid., par 1c.

[18]Ibid., par 1d.

[19]Ibid., par 1e.

[20]Ibid., 3rd Indorsement, 10 Jul 1943.

[21]Organization Chart, 10 Jul 1943; Chart XII of this study; Memorandum from the Executive Officer, SGO, to the Control Division, ASF, 28 Aug 1945 (SGO, Record Room, 300.7-1).

[22]SGO Office Order 466, 14 Jul 1943; Annual Report of the Operations Service, SGO (The Prisoner of War Liaison Unit), 1944 (Historical Division, SGO, 319.1-2).

[23]SGO Office Order 441, 12 Jul 1943.

[24]Memo for all Officers, SGO, 9 Aug 1943 (Historical Division, SGO); Inclosure 2, Memorandum from the Acting Director, Control Division, SGO, to the Director of the Control Division, ASF, 23 Aug 1943 (Record Room. SGO, SPMC 024.-1).

[25]Ibid., Inclosure 2.

[26]Memorandum from Executive Officer, SGO, to Control Division, ASF, 23 Aug 1943 (Record Room, SGO, 300.7-1); Army Service Forces Organization Manual (301), Revision of 1 Oct 1943, p. 306.00 4-5 (Historical Division, SGO).

[27]Memorandum from the Director, Control Division, SGO, to the Director, Historical Division, SGO, 20 Jun 1944, p. 8 (Historical Division, SGO, 319.1-2).

[28]SGO Office Order 630, 26 Aug 1943; ASF Organization Manual (301), 1 Oct 1943, p. 306.00 4.

[29]SGO Office Order 648, 1 Sep 1943.

[30]Yates, opus cited, p. 59; Supply Service Memorandum No. 1, 29 Nov 1943.

[31]Summary Report of Control Division, June 1943 to June 1944, 16 Jun 1944 (Historical Division, SGO, 319.1-2).

[32]Section II, Army Service Forces Circular No. 79, 15 Sep 1943.

[33]Supply Service Memorandum No. 1, 29 Nov 1943.

[34]SGO, Office Order 837, 27 Oct 1943.

[35]SGO Office Order 109, 3 Mar 1943.

[36]SGO Office Order 797, 9 Oct 1943.

[37]SGO Office Order 823, 21 Oct 1943; Memorandum from the Commanding General, Army Service Forces, for . . . Chiefs of Technical Services, subject: Personnel Control Units, 29 Sep 1943 (Historical Division SGO, 230.-1).

[38]SGO Memorandum for all officers, 28 Aug 1943.

[39]SGO Memorandum for all officers, 17 Sep 1943; SGO Office Order 725, 20 Sep 1943.

[40]SGO Office Order 165, 26 Mar 1943; Office Order 666, 3 Sep 1943.

[41]SGO Office Order 702, 14 Sep 1943; Foreward to The Bulletin of the U.S. Army Medical Department, V, No. 6, (June 1946).

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CHAPTER V

REORGANIZATIONS DURING 1944

During his first six months in office, The Surgeon General, Major General Norman T. Kirk, had succeeded in making notable economies in the operation of the fiscal and supply activities of the Medical Department. While problems still remained to be solved in these fields, he was able in the fall of 1943 to devote more attention to securing a more effective organization to carry out the professional aspects of the Medical Department mission. In the effort to achieve this end, a series of readjustments and two additional reorganizations were made in the Office of The Surgeon General during the period from November 1943 to September 1944. These reorganizations were designed to provide for greater decentralization of authority; to coordinate, through the Operations Service, the activities of all divisions contributing to Medical Department operations; and to separate administrative activities from advisory functions.

The Separation of The Professional and Preventive Medicine Activities

Reconstruction of the Office of The Surgeon General, according to the above plan, actually began at the center of professional activity. In November 1943, the Professional Service consisted of an unwieldy grouping of seven more or less unrelated professional divisions. The enormous task of administration for the whole of the service was vested in a single Chief of the Service, who was responsible for its entire operation. The Surgeon General apparently believed that the problems relating to the administrative management of the many phases of preventive medicine should be separated from the purely professional problems peculiar to the rest of the service. Sometime before 3 December 1943, he directed that the Chief of the Professional Service reconsider the organization of his service, and, together with the Director of the Preventive Medicine Division, develop plans for the separation of the Preventive Medicine Division from the rest of the service. The Director, Control Division, SGO, was designated to assist both principals with the planning and to act as coordinator for The Surgeon General in presenting the final proposal to the Control Division, Army Service Forces, for approval.[1]

The planners agreed that all activities relating to the work of the Nutrition Branch properly belonged in the field of preventive medicine. Following this decision, each Chief prepared a detailed chart to be used as the

working basis for his service.[2] The result of this activity was published in an office order on 1 January 1944 which established the Preventive Medicine Service and redefined the organization of the Professional Service.[3]

The reorganized Professional Service consisted of eight divisions and two branches. The two branches, established as activities in the Office of the Chief, had been transferred to this level because they related to the activities of more than one division. The Editorial Branch, formerly located in Preventive Medicine Division, was charged with management and issue of The Bulletin of the Army Medical Department. The Procurement and Advisory Branch, formerly a branch of the Medical Division, was made responsible for rendering professional advice on medical supplies.

The most important change made in the service was the establishment of the Neuropsychiatry Branch as a division. This change had been strongly recommended by the Chief of the Service in order to properly care for the great increase in neuropsychiatric problems. It was hoped that divisional status "would facilitate getting an outstanding man, and . . . furnish a strong basis for obtaining a substantial increase in officer and civilian allotment, because of the increase in the job which necessitated making this a division."[4] The work of the division was to be accomplished through the Psychiatry, Neurology, and Mental Hygiene Branches. Another important change raised the Physical Standards Branch, Medical Division, to division level in order that physical standards might be better formulated and the general supervision over physical examinations, incident to admission into and separation from the military service, might be more adequately exercised. The activities of the division were conducted by the Induction, Appointments, and Dispositions and Retirements Branches.

The Medicine Division (formerly Medical Division) was rearranged into three branches: the Medicine Branch became the General Medicine Branch without essential change in function; a Tropical Disease Treatment Branch was activated to establish policies and procedures for the diagnosis and treatment of tropical diseases in the Army; and the control of tuberculosis in the Army was delegated to a new Tuberculosis Branch. The Medicine Division lost four branches in the process of reorganization, in addition to the above changes. The Nutrition Branch was assigned to the Preventive Medicine Service; the Neuropsychiatry and Physical Standards Branches were made full divisions in the Professional Service; and the Procurement Advisory Branch was established as an activity directly under the Chief of the Service.

A general revision also took place in the Surgery Division (formerly Surgical Division). A General Surgery Branch was established in place of the Surgery Branch; the Physical Therapy Branch was deleted; and the Orthopedics, Transfusion, and Chemical Warfare Branches were added. No change was made in the Radiation Branch. In the Reconditioning Division, the War Exhaustion Branch was dropped and an Educational and Vocational Rehabilitation Branch added. The specialized problems relating to the war blinded and deafened were to be provided for in a newly-established Blind and Deaf Rehabilitation Branch. The remaining units of the Professional Service were little changed. The Nursing Division added a Nursing Morale Branch in order to provide liaison for the Army Nurse Corps in public relations matters. No changes were made in the organization of the Dental or Veterinary Divisions.[5]

The Chief of the Service continued to direct and coordinate the activities of the Professional Consultants in Aviation Medicine, Internal Medicine, Surgery, Neuropsychiatry, Reconditioning, Dentistry, Veterinary Medicine, and Tuberculosis.

The weakest point in the January 1944 reorganization of the Professional Service was in the failure to provide deputies to assist the Chief of the Service in the over-all administration of professional matters. This shortcoming was soon remedied, however, by the appointment of a Deputy Chief in January and the assignment of an Executive Officer in February. By the end of the fiscal year, an Assistant Chief had been assigned. Further aid, in addition to personnel, was given to free the Chief of Service from many of his administrative tasks when the Deputy Chief assumed responsibility for the Editorial Branch. In addition, a unit, designated as the Professional Inquiry Branch, was organized in the service to handle the many inquiries formerly directed to the Chief of the Service, which required professional investigation for the Office of The Surgeon General.[6]

The Preventive Medicine Service was established by the same order which recast the Professional Service. The organization of this service, however, provided for both a Chief of the Service and a Deputy Chief. This was a wise decision, for in addition to administering the ten branches established in the service, the Chief of the Service directed the activities of the Board for the Investigation and Control of Influenza and other Epidemic Diseases in the Army. The Deputy Chief also served as Director of the United States Typhus Commission.[7] In the establishment of the service, seven branches of the old Preventive Medicine Division were

reorganized as divisions. These branches now constituted the Sanitation and Hygiene, Epidemiology, Laboratories, Sanitary Engineering, Venereal Disease Control, Occupational Health, and Medical Intelligence Divisions. The Tropical Disease Control Section of the former Epidemiology Branch also became a separate division and was composed of four branches: Control Policies, Education, Field Survey, and Malaria Control. In addition to the divisions which stemmed from former branches, two new divisions were added: the Nutrition Division, formerly a branch in the Medical Division, Professional Services; and the Civil Public Health Division which was established by The Surgeon General in recognition of the Army's responsibilities for the maintenance of the health populations in occupied and liberated countries. The latter division assisted in the selection of specialized personnel, maintained contact with field operations, and integrated its program with those of other agencies. In order to fulfill its mission the Communicable Disease and Laboratories, Public Health Engineering, Nutritional Deficiencies, and Maternal and Child Health Branches were established.[8]

To maintain efficient administration over the ten divisions, an Assistant Chief, Preventive Medicine Service, was designated in February 1944. He exercised general control over the Sanitation and Hygiene, Epidemiology, and Tropical Disease Control Divisions, reporting directly to the Chief of the Service on the activities of these divisions.[9] In March the position of Executive Officer, Preventive Medicine Service, was created.

The reorganization of the Professional Service and the separation of preventive medicine activities from the Professional Service achieved a greater decentralization of authority and constituted the first stage in the marked effort to reorganize the professional activities of the Office of The Surgeon General.

Reorganization for Operations

The realignment of the Professional and Preventive Medicine Services constituted the first phase in a comprehensive program for the reorganization of the Office of The Surgeon General. Planning for the second phase centered around the activities and functions of the Operations Service, although other services would be affected by the changes made in the control of all operations activities. In the first place, it was believed that the existing organization for hospitalization and evacuation was not adequate to handle the planning for the expected heavy load of casualties from the European Theater. A reorganization

and expansion of the Hospital Administration Division was believed to be urgently needed. In the second place, The Surgeon General had decided that all matters which required attention from more than one of the operating services in the Office of The Surgeon General should be supervised and correlated by the Operations Service.[10] The need for coordination was especially apparent in three distinct areas. The first broad field of activity which needed coordination related to the civil affairs activities in occupied territories. In June 1943 a Board to prepare, develop, and implement the medical portions of the War Department program to aid civilian populations in liberated countries had been established. The actual responsibility under this program had been divided between the Supply, Veterinary, Dental, and Preventive Medicine Services. The Surgeon General decided that the Operations Service should be responsible for assuring adequate and coordinated action by the several services involved in this program.[11] As a result of this decision, it was proposed to establish a branch for this purpose in a Special Planning Division of the Operations Service.

A similar necessity existed to assure adequate and correlated actions of the various services in dealing with the medical needs of women in the Army. It will be recalled that an officer had been appointed to maintain liaison with Headquarters, Women's Army Corps in June 1943, but the responsibilities of the various services had never been absolutely fixed. To remedy this condition and to assure greater coordination, it was proposed, to establish a Women's Medical Unit under the Operations Service.

The third area in which greater coordination was needed related to supply planning activities. These activities demanded careful coordination between the Procurement Advisory Branch of Professional Service, the Field Equipment Branch of Operations Service, the Supply Service in Washington and in the Army Medical Purchasing Office, and at times, the Medical Field Equipment Laboratory at Carlisle Barracks. The number of agencies involved in the process had often led to bad teamwork. For example, decisions by the Professional Service, which necessitated immediate changes in the catalog, often upset the routine of the Supply Service. The Supply Service had attempted to improve supply planning activities by establishing a Supply Planning Division, but this arrangement did not work out to the satisfaction of all agencies involved. The functions assumed by the Supply Planning Division overlapped those of units in the other services. Because of the many difficulties involved, it was "believed that the sound solution is, in accordance with the principal . . . followed in other instances involving necessity for action by more than one Service, to assign to the Operations Service the responsibility of seeing that new supply items

. . . are promptly developed . . . and that the activities of the Procurement Advisory Branch, Field Equipment Development Branch and the New York Medical Purchasing Office are properly coordinated."[12]

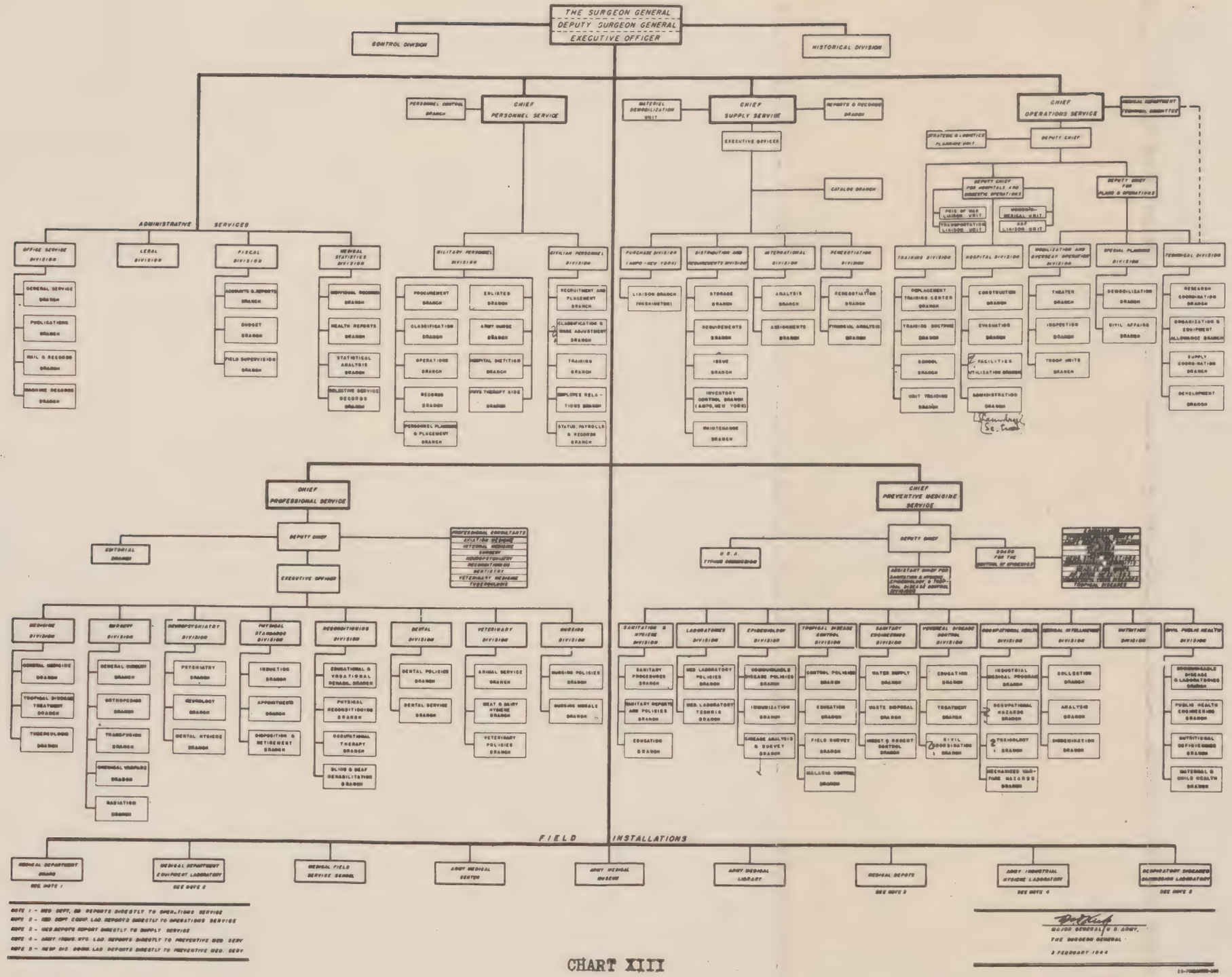
In addition to these recommendations, a very strong argument was advanced to increase the power of the Chief of the Operations Service. It was proposed that a new post of Assistant Surgeon General be created with authority to coordinate all the services in the Office of The Surgeon General, and further, that the Chief of Operations serve in both capacities. The Surgeon General was not yet ready to accept this proposal, but held it in abeyance until the success of the other features of the reorganized Operations Service could be determined.[13]

The new proposal for the reorganization of the Office of The Surgeon was approved on 3 February 1944, although all the features of the plan were not set into immediate operation.[14] The reorganization of the Operations Service provided for a Chief of Operations and a Deputy Chief of Operations. Two units were made the direct responsibility of these officers. The Medical Department Technical Committee was placed under the direct authority of the Chief of Operations. This committee was one of the most important in the Medical Department, for it reviewed and approved the standardization and reclassification of Medical Department supplies and equipment. The committee had been standing committee during the war years; and placing it at this level indicated the importance The Surgeon General attached to coordinating research activities in the Operations Service.

Provisions were made for Strategic and Logistics Planning Unit under supervision of the Deputy Chief. Actually, the functions of this unit were the personal responsibility of the Deputy Chief until the unit was established on 15 March 1944 and a Director was assigned in April. The function of the unit was "to determine the adequacy of all phases of Medical Department operations, and plans therefor, to the extent necessary to insure timely placing of sufficient personnel, equipment and supplies to meet all authorized requirements."[15]

The remaining functions of the Operations Service were grouped, with the exception of training activities, under the control of a Deputy Chief for Plans and Operations and a Deputy Chief for Hospitals and Domestic Operations. The Deputy Chief for Plans and Operations supervised the activities of the Mobilization and Overseas Operation, Special Planning, and Technical Divisions. All these divisions were new and require, at this point, a few words of explanation.

ORGANIZATION CHART
OFFICE OF THE SURGEON GENERAL
WAR DEPARTMENT



NOTE 1 - MED DEPT, GD DEPOTS DIRECTLY TO OPERATIONS SERVICE
NOTE 2 - MED. DEPT. EQUIP. LAB. REPORTS DIRECTLY TO OPERATIONS SERVICE
NOTE 3 - MED DEPOTS REPORT DIRECTLY TO SUPPLY SERVICE
NOTE 4 - ARMY INDUS. HYG. LAB. REPORTS DIRECTLY TO PREVENTIVE MED SERV
NOTE 5 - RESP DIS INTEN. LAB. REPORTS DIRECTLY TO PREVENTIVE MED. SERV

Norman T. Kirk
MAJOR GENERAL U.S. ARMY,
THE SURGEON GENERAL
5 FEBRUARY 1944

CHART XIII

The Mobilization and Overseas Operation Division was developed from the branch of the same name in the former Plans Division. The division was divided into three branches designed to coordinate The Surgeon General's planning for field operations. The Theater Branch prepared the medical sections of war plans, maintained records concerning medical matters for overseas forces, and recommended the medical support essential for new task forces. In order to accomplish these functions, the branch maintained liaison with the Operations Planning Division, War Department General Staff, and with the Planning Division of Headquarters, Army Service Forces. The Troop Units Branch planned and recommended the number and type of Army Service Forces medical units required for overseas duty and scheduled the activation of units of this type. In this planning the branch closely coordinated its activities with those of the Theater Branch and the Training Division, Operations Service. The Inspection Branch was the third branch of the division. This branch, formerly a branch of the old Plans Division, continued to receive and review overseas reports; maintained the current records of all inspection trips made by personnel in the Office of The Surgeon General; and interviewed and circulated the reports of interviews with medical personnel returned from overseas.

A Special Planning Division was established which replaced the Plans Coordination Branch of the old Plans Division. It was established with the express purpose of coordinating certain functions relating to the activities of more than one division. The first of these, planning for demobilization, had been a major function of the old branch, and was continued in the Demobilization Branch. The branch coordinated all planning activities within the Office of The Surgeon General and all liaison with outside agencies relating to demobilization. A Civil Affairs Branch was established in the Special Planning Division to coordinate all activities relating to medical relief, including supplies, sanitation, training, personnel, and medical and veterinary service in occupied countries during the period of military responsibility. The branch maintained liaison for all civil affairs matters, except for those functions which were specifically delegated to the Civil Public Health Division, Preventive Medicine Service.[17] Later, the Civil Affairs Branch was charged with developing the program for medical and sanitary supplies for civilians in occupied and liberated areas. In this program it utilized the advice and assistance of The Surgeon General's Civil Affairs Supply Board.[18]

A third division established under the Deputy Chief for Plans and Operations was designed to provide a single unit through which would flow all material relating to the development, modification, or classification of items of supply or changes in their bases of issue. The new unit, named the

Technical Division, merged the personnel and functions of the Research Coordination and Field Equipment Development Branches of the Plans Division, the Procurement Advisory Branch of the Professional Service, and in addition, absorbed a portion of the personnel and functions of the Supply Planning Division, Supply Service. The primary functions of the Technical Division included the development and classification of Medical Department supplies and equipment; the determination of their bases of issue; the preparation and review of Tables of Organization and Equipment, Medical Department Equipment Lists, and Tables of Allowances; the execution of the administrative details of the Medical Department Research Program; and the preparation of reports relating to that program. The division was responsible for coordination and review of specifications for Medical Department supplies, and for the administrative and clerical activities of the Medical Department Technical Committee. While much of "the actual research and review of scientific material would continue to be the responsibility of other units in the Office of The Surgeon General, it was, however, the responsibility of the [Technical Division] to translate recommendations made by the various professional groups into concrete plans on which may be based procurement and issue of items of supply and tables of organization for their employment. The division [was] in a sense a clearing house between the Supply Service and the other divisions and services of The Surgeon General's Office."[19]

The reorganization of the Operations Service in February 1944 combined all functions relating to Zone of the Interior hospitalization and evacuation under a Deputy Chief for Hospitals and Domestic Operations. This officer, who also served as Director of the Hospital Division, was responsible to the Chief, Operations Service. This scheme made it possible for the Operations Service to concentrate the increasing responsibility for Zone of Interior medical operations. To assist the Deputy Chief in the discharge of his duties, a Hospital Division composed of four branches was organized, and four separate liaison units were established. The first of these units was the Women's Medical Unit. It was established, under the direction of a woman medical officer, to develop policies and coordinate all activities within the Office of The Surgeon General relating to the medical care and welfare of women in, or connected with, the Army. The chief of this unit had served as The Surgeon General's Liaison Officer to the Women's Army Corps, and was designated in February 1944 as Consultant for Women's Health and Welfare.[20] The chief problems handled in the unit concerned the medical care, physical fitness, and the utilization of Women's Army Corps personnel in Medical Department installations. The second separate unit, the Prisoner of War Liaison Unit, had been established during July 1943 in the Office of The Provost Marshal to represent

The Surgeon General in all matters relating to sick and wounded prisoners of war. A third unit, known as the Army Air Forces Liaison Unit, was charged with the coordination of planning for hospitalization in Army Air Forces hospitals in the Zone of the Interior. The Transportation Liaison Unit was the fourth separate unit established under the direction of the Deputy Chief for Hospitals and Domestic Operations. This unit was designed to strengthen the position of Transportation Liaison Officer, and formed the basis for a much more comprehensive plan to coordinate the efforts of the Chief of Transportation and The Surgeon General in planning for the evacuation of the sick and wounded from overseas commands. It was apparent that both of these major agencies would be forced to pool their information and resources if the anticipated requirements in connection with evacuation were to be met. It was equally clear that in order to meet these requirements, The Surgeon General would be forced to control bed space in the named general and other hospitals used for the treatment of patients evacuated from overseas and, together with The Chief of Transportation, have the authority to direct the transfer of patients to any available space. In order to accomplish this mission, it was necessary to obtain authority to cut across command channels. The authority to coordinate the efforts of both technical services was granted, and a Medical Regulating Unit was established in May 1944.[21] This unit actually operated under the Deputy Chief for Hospitals and Domestic Operations, but was physically located with the Movements Division, Office of The Chief of Transportation, in order to provide closer coordination and greater accessibility of information. The Transportation Liaison Unit was absorbed into the new unit; and the Evacuation Branch was transferred from the Hospital Division, Operations Service, to become the Bed Credit Section of the Medical Regulating Unit. The new unit provided the means to evacuate and transport thousands of overseas patients to a place of definitive treatment with the least possible delay and confusion.

One of the primary reasons for the reorganization of the Operations Service in February 1944 was the belief that the Hospital Administration Division was inadequately organized and staffed to carry the responsibility of planning for the heavy load of casualties expected during 1944. Careful study of the problem, made at the request of The Surgeon General, led the Director of the Control Division to report: "A reorganization and large expansion of this division, to make plans to handle the expected heavy load of casualties within the next few months, is urgently necessary. This matter is of such paramount moment as to deserve, I believe, your fullest support . . . Immediate

broad scale effort and planning seem to be urgently needed."[22]

The expansion of the Hospital Administration Division to form the Hospital Division constituted a major part of the reorganization of the Operations Service, and four branches were established to accomplish its mission. The Evacuation Branch of the old Hospital Administration Division was continued for a short time as a branch in the new plan, but was soon detached from the division to form the Bed Credit Section of the Medical Regulating Unit. A Facilities Utilization Branch was established to study the means of obtaining maximum use of facilities and personnel in Army hospitals. The first study undertaken by the branch was that of estimating the number of evacuees which could be expected, once major operations began. As a result of this study, steps were taken to increase the number of beds under the control of general hospitals and to provide convalescent facilities in order to care for potential needs. Detailed studies were made, at the direction of the Deputy Chief of Staff, U.S. Army, to determine the feasibility of an integrated plan of hospitalization in the Zone of the Interior without respect to command jurisdiction. These investigations resulted in an agreement with the Army Air Forces, which led to the establishment of 60 regional hospitals designed to relieve the burden on general hospitals. The adoption of this plan led to economy in the use of personnel and equipment. Additional studies were made to determine work loads in general and station hospitals, and to assess the degree of successful utilization of specialized personnel in all medical establishments.[23] The studies and proposals of the Facilities Utilization Branch proved to be increasingly useful to the Chief, Operations Service, and to The Surgeon General; and the responsibilities of the branch steadily developed to the point where it seemed desirable to raise the branch to the status of a division. The Resources Analysis Division was established in October 1944 "to analyze and evaluate the current and prospective mission of the Medical Department in the major commands . . . and to submit recommendations to the Chief of Operations Service . . . [showing] how available means can be utilized to maximum efficiency."[24] All planning in personnel matters, "except for such aspects as related to personnel as individuals" (which were the continued responsibility of the Personnel Service), was made the direct responsibility of the Resources Analysis Division.[25] In assuming these functions, the division absorbed most of the functions of the Strategic and Logistics Planning Unit which had been established in April 1944, and the Strategic and Logistics Planning Unit was abolished in November.[26] No essential changes were made in the organization or the responsibility of the Resources Analysis Division for the remainder of the war.

The two remaining branches established in the Hospital Division in February 1944 continued as branches of the division for the remainder of the war. An Administrative Branch maintained advisory supervision over the administration of Army Hospitals, inspected the administrative procedures of hospitals in the effort to increase efficiency in operation, and rendered advice to the Director, Hospital Division, on all phases of the Medical Department laundry program. The Construction Branch coordinated the efforts of the Office of The Surgeon General and Office of The Chief of Engineers in approving hospital sites, developing and changing plans for new hospitals, and surveying civilian facilities offered for medical use. The branch collaborated with representatives of the Transportation Corps in preparing plans for hospital ships and hospital facilities on other ships. It was charged with maintaining contact with the Requirements Section, Headquarters, ASF, in determining the need for hospital construction and with Headquarters, Army Air Forces, in matters of hospital needs at Army Air Forces stations. In addition, it represented The Surgeon General in all contacts with the Federal Board of Hospitalization.[27]

It should be pointed out that no change was made in the organization of Training Division during the general reorganization of the Operations Service. At the expressed desire of the Chief, Operations Service, the Director of the Training Division continued to report directly to him, and the division was not placed under the control of either Deputy Chief.[28] In February 1944, the Training Division consisted of a Director's office and the Replacement Training Center, School, Training Doctrine, and Unit Training Branches. In May 1944, in conformity with changes in the method of training Army Service Forces troops, the names of the branches were redesignated as the Regular Training, School, Training Doctrine, and Readiness and Requirements Branches. To understand the reasons which brought about these new designations, a brief statement concerning the changes in the method of training Army Service Forces troops is necessary.

Before April 1944, medical units had been activated and then placed in training. On 15 April 1944, this plan for training was abolished.[30] Henceforth, personnel for Army Service Forces medical units would be trained at Medical Replacement Training Centers or Medical Department Enlisted Technicians Schools prior to the actual activation of the unit. The new plan for training placed greater responsibility on each Medical Department Training Center for, in addition to training loss replacements, these centers now conducted preactivation training of the men destined for medical units. In order to provide supervision over the training center participation in the plan, the Replacement Training

Center Branch of the Training Division was reorganized as the Regular Training Branch with greatly enlarged supervisory functions. More effectively to carry out the preactivation training plan, the Unit Training Branch was reorganized as the Readiness and Requirements Branch. The branch was charged with the responsibility of providing training plans of all medical units in preactivation training, with furnishing all enlisted technicians not actually trained within the centers, and with the inspection of units to insure their readiness for movement. Both branches had vital parts in the program, and close cooperation and liaison were maintained between the Readiness and Requirements Branch and the Regular Training Branch to insure its success. The School Branch continued to develop and direct plans for the operations of the special service and technical schools of the Medical Department, including the Medical Administrative Corps officer candidate schools; and to formulate policies, coordinate, supervise, and inspect the technical training of Medical Department personnel in military installations and civilian institutions. The Training Doctrine Branch was charged with continued responsibility for the promulgation of training doctrine through visual training aids and training literature.[31] The organization of the Training Division, as revised in May 1944, continued unchanged during the remainder of the war, although a later change in the organization of the Operations Service placed the division under the control of the Deputy Chief for Plans and Operations.

The reorganization of the Office of The Surgeon General in February 1944 carried out important changes in the Operations Service designed to improve the direction and supervision of Medical Department functions and activities. Concurrently, realignments were made in other services and divisions which supplemented the developments in the Operations Service. All plans for more expert hospitalization and faster evacuation ultimately depended upon medical personnel to provide the needed services at the right time and at the right place. But The Surgeon General did not have control over medical personnel. The assignment of personnel, except those under the direct authority of The Surgeon General in Class IV installations and in his own Headquarters, had been decentralized to the Service Commands. Thus, in order to obtain the needed specialists in various medical installations, The Surgeon General was compelled to obtain the consent of the Service Commander in each individual case. The inevitable delay, red tape, and complications caused by this procedure delayed the program and convinced The Surgeon General that he needed greater authority over the assignment of medical personnel in the Army. In the hope that such authority would be granted, he planned to improve the organization of the Personnel Service in his own office. At his request the Director, Control Division, SGO, surveyed the Personnel

Service. The results of this study were incorporated in a report made by the Director, Control Division, which indicated that Headquarters, Army Service Forces, and many senior officers in the Office of The Surgeon General had little confidence in the adequacy of the Personnel Service. This lack of confidence appeared to be based upon three factors. In the first place, it was thought that the service did not possess records adequate enough to enable The Surgeon General to select and assign specialists; in the second place, it was believed that no long range planning for the utilization of personnel was carried on, as distinguished from day to day action in individual cases; and, in the third place, it was believed unwise for the Personnel Service to make assignments without reference to other services in the office. The report concluded that: "the power to ration medical personnel from a central source should be vested in The Surgeon General. But while such power is urgently needed, my information indicates that such request at this time would be unlikely to succeed because of the attitude of Headquarters [ASF] toward the inadequacy of records and the organization to utilize such power . . ."[32]

Steps were taken immediately to strengthen the Personnel Service. A Personnel Control Branch was established in the Chief of Personnel to provide for the "effective utilization of personnel in the Office of The Surgeon General and in the field installations." This branch acted as the clearing-house for The Surgeon General's Personnel Control Unit.[33] A Personnel Planning and Placement Branch was established in the Military Personnel Division in order to provide the means for long range planning and to coordinate with other interested services and divisions the placement of key personnel. It was hoped that the creation of these two branches would correct the major weaknesses in the organization of the service. In addition, the Army Nurse, Hospital Dietitian, and Physical Therapy Aides Branches were added in the Military Personnel Division to control the planning for and utilization of the women's components of the Medical Department.[34]

The 1944 reorganizations were marked by certain changes in the Supply Service. The Supply Planning Division was abolished in February, and most of its planning functions were transferred to the Technical Division, Operations Service. Most of the remaining functions were transferred to the Supply Service overhead; the Catalog Branch was established as an activity under the newly created post of Executive Officer of the Supply Service; and a Materiel Demobilization Unit was added in the Office of the Chief. A much more thorough reorganization of the Supply Service followed in June 1944. At this time the Distribution and Requirements Division was abolished, and the Storage and Maintenance, Issue,

and Stock Control Divisions were established. The Renegotiation Division was transferred to the Army Medical Purchasing Office, although certain renegotiation activities continued in Washington under the control of a Liaison Unit of the Renegotiation Division. At the same time certain Supply Service activities were grouped under the office of the Deputy Chief for Supply Control, who coordinated the activities of the Stock Control and Purchase Divisions and acted as advisor to the Chief of the Supply Service in matters pertaining to these divisions. An office of Deputy Chief for Storage Operations was also established, which provided an advisor to the Chief, Supply Service, for depot operations.[35]

Certain other changes were made in the organization of the Office of The Surgeon General during 1944 which should be noted at this time. The Historical Division was removed from the Administrative Service and established as a separate division under the direct control of the Deputy Surgeon General, where it remained for the rest of the war. The Office of Technical Information was dissolved in February 1944, and a Technical Information Branch was established in the Control Division. This branch apparently carried on all of the functions of the Office of Technical Information. The new arrangement did not work out satisfactorily, and a Technical Information Division was organized in May to operate as the sole representative of The Surgeon General and all personnel in the Office of The Surgeon General in all public relations matters.[36] Any inquiries made by the press or other publicity media were to be answered directly by the Technical Information Division. Further, the text of all public addresses and all manuscripts was subject to review by this agency before publication. In addition to these duties, the division was charged with the preparation of a long range public relations program for the Medical Department. To carry out its functions, the new division absorbed the Technical Information Branch and the Nursing Morale Branch, Nursing Division, Professional Service.

The Reorganization of August 1944

The reorganization of the Office of The Surgeon General in August 1944 was the final phase in a long series of developments designed to decentralize authority, to coordinate all activities contributing to Medical Department operations, and to separate administrative activities from advisory functions. The ways in which to achieve these ends had been the subject of continuous study by the advisors of The Surgeon General. The informal preliminary report of their investigations, made in June 1944, embraced all three aspects of the problem.[37]

The Surgeon General was urged to delegate all powers "aside from your functions of over-all supervision, decisions of major policies and conduct of matters which no one else can handle" to his aides. An additional fulltime assistant was recommended. The Deputy Surgeon General would represent The Surgeon General in all matters except where the former's personal appearance was absolutely necessary; he would determine the matters on which The Surgeon General should be informed; and would have the blanket authority to take action on all the rest. A second assistant, or Assistant Surgeon General, would be appointed who would have clear delegation of authority to act for The Surgeon General on all matters inside the Office of The Surgeon General. It was further proposed that the Chief, Operations Service, would be named as the Assistant General in order to make certain that all matters of importance would clear through the Operations Service. The Surgeon General had repeatedly approved of this idea in principle, but, in actual practice the plan had never worked out because the Operations Service was on a parity with other services and was not recognized as having authority over them.

The second recommendation concerned the operation of the Personnel Service. It was believed that all assignments of medical personnel should be made upon the recommendation of the division concerned, and that the Personnel Service should do the same general character of work done for the whole Army by The Adjutant General. The service would keep the records, issue orders, and carry out all administrative work incident to those functions, but it should not exercise discretionary decisions over assignments.[38] It will be recalled that proposals similar to the first and second recommendations had been made to The Surgeon General before the February 1944 reorganization, but subsequent reorganizations had not put them into force. To insure that the second suggestion would bear fruit, the Director of the Control Division further recommended that both divisions of the Personnel Service be abolished and that they be made separate divisions in the Administrative Service.

The third proposal pertained to the organization of the Professional Service. It stressed the fact that the service was an "artificial composite of hetrogeneous elements, many of which have no real connection with the others."[39] It further pointed out that the service engaged in operations activities which overlapped the work of the Operations Service, and that the Directors of the Medicine, Surgery, and Neuropsychiatry Divisions reported, not to the Chief of the Service, but directly to The Surgeon General. It was recognized, however, that these advisors in three of the principal fields of The Surgeon General's activities should not be

separated from him. Because of these facts, four major recommendations were made. First, the advisory groups (comprising Medicine, Surgery, Neuropsychiatry, and Reconditioning) should determine the policies of their respective groups and report directly to The Surgeon General. To do this, these groups should be separated from the Professional Service and set up as Staff Divisions on a separate level from the operating services of the office. In so far as their work involved proposals for changes in hospitalization (such, for illustration, as setting up reconditioning camps or hospitals, or of psychiatric hospitals, or making changes which would affect the operation of hospitals), their policies and advice would be carried into effect through the Hospital Division of the Operations Service. Second, the Dental and Veterinary Divisions should be established as separate divisions and report directly to The Surgeon General or to the Assistant Surgeon General. Third, the Nursing Division should be incorporated in the Hospital Division, except for those functions which related entirely to personnel activities. This proposal was regarded as logical, because of the similarity of the activities in the Hospital and Nursing Divisions. Fourth, the Physical Standards Division should be divided under this plan; the professional decisions as to policy would be made the responsibility of the Medicine, Surgery, and Neuropsychiatry Divisions respectively, and the actual operating work of reviewing records or applying policies to specific cases would be placed in the Operations Service.

Apparently, The Surgeon General was willing to accept the proposals set forth in the June report. The plan presenting these proposals was then submitted for approval to the Director of the Control Division, Army Service Forces. The proposal to demote the Personnel Service was disapproved by the Director, Control Division, ASF, because it was the fixed policy of the Army Service Forces to insist that all civilian and military personnel activities in a technical service be combined under a single head. The plan was then revised in the Control Division, SGO, and a scheme which maintained the existing Civilian and Military Personnel Divisions, was presented to The Surgeon General with the suggestion that the Chief of the Personnel Service could also serve as the Director of the Military Personnel Division.[40] The Director, Control Division, ASF, had also objected to the plan for revision of the Professional Service and did not deem it advisable to formally end the service as a unit.[41] To overcome the objections made by the Director, Control Division, ASF, The Surgeon General's advisors proposed that:

> The Professional Service be limited to Medical, Surgical, Psychiatric, Dental, and Veterinary Divisions, all of which would, as a practical matter, operate separately.

The Women's Medical Unit, a professional unit which did not belong in the Operations Service, should be made a unit in the Professional Service.

The personnel aspects of the work of the Nursing Division should be absorbed into the Military Personnel Division, and a Nursing Branch should be established under the Hospital Division.

The Physical Standards Branch should be transferred to the Administrative Service in order to parallel the structure of Headquarters, ASF.

The Reconditioning Division should be renamed the Reconditioning and Convalescence Division to take cognizance of the large convalescent program in which it was interested, and that it be made a branch of the Hospital Division.[42]

The suggestions of the Control Division were adopted in part by The Surgeon General, who approved a new organizational chart incorporating the changes on 24 August 1942 (See Chart XIV). This was followed by an office order which set the new organization plan in operation and included the following features:

The post of Assistant Surgeon General was established. The Assistant Surgeon General

will act for The Surgeon General in coordinating the work of the Operations Service, the various professional divisions, the Military Personnel Divisions, and such activities for other divisions and services as affect operations. Detailed arrangements to this end will be worked out by The Assistant Surgeon General in accordance with the following principles:

Acts involving operations will be cleared through Operations Service.

The Operations Service will hereafter be responsible for personnel planning.

The Military Personnel Division will keep all military personnel records and will process all military personnel actions. Assignments of key personnel will be made only with the concurrence of the appropriate service or division particularly concerned with, or possessing special knowledge of, the qualification of the officer and the requirements of specialty assignments.

The Administrative Service was dissolved and the Fiscal, Legal, and Office Service Divisions were directed to report to the Executive Officer.[44] In reality, this caused little change in existing arrangements, for the Executive Officer had acted as Chief of the Administrative Service.

The Professional Service was dissolved and four professional divisions were created: Medical Consultants, Surgical Consultants, Neuropsychiatric Consultants, and Reconditioning Consultants, Divisions.[45]

The Dental and Veterinary Division were continued without change. The Nursing Division, as such, was dissolved, but all personnel matters and related aspects of the Army Nurse Corps program were made the responsibility of the Army Nurse Branch of the Military Personnel Division.[46] All policy making aspects of the Army Nurse Corps were transferred to the Nursing Division, Professional Administrative Service.

A Professional Administrative Service was formed in place of the Administrative Service envisaged by the plan of the Control Division. This service grouped together the following divisions and units:

The Physical Standards Division, which was formerly part of the Professional Service;

The Nursing Division, including only policy making aspects;

The Medical Statistics Division, which formerly reported directly to the Executive Officer;

The Professional Inquiries Unit, formerly part of the Professional Service; and

The Women's Health and Welfare Unit, formerly the Women's Medical Unit in the Operations Service.

The Professional Administrative Service was charged with the processing of all changes in Army Regulations requested by other units in the Office of The Surgeon General.[47]

The Editorial Branch, which had been a part of the Professional Service, was made a separate unit and was ordered to report directly to the Deputy Surgeon General.[48]

The changes made in the organization of the Office of The Surgeon General in August 1944 completed all phases of the program to decentralize authority, to coordinate the activities of all operating divisions, and to separate the administrative

ORGANIZATION CHART
OFFICE OF THE SURGEON GENERAL
ARMY SERVICE FORCES

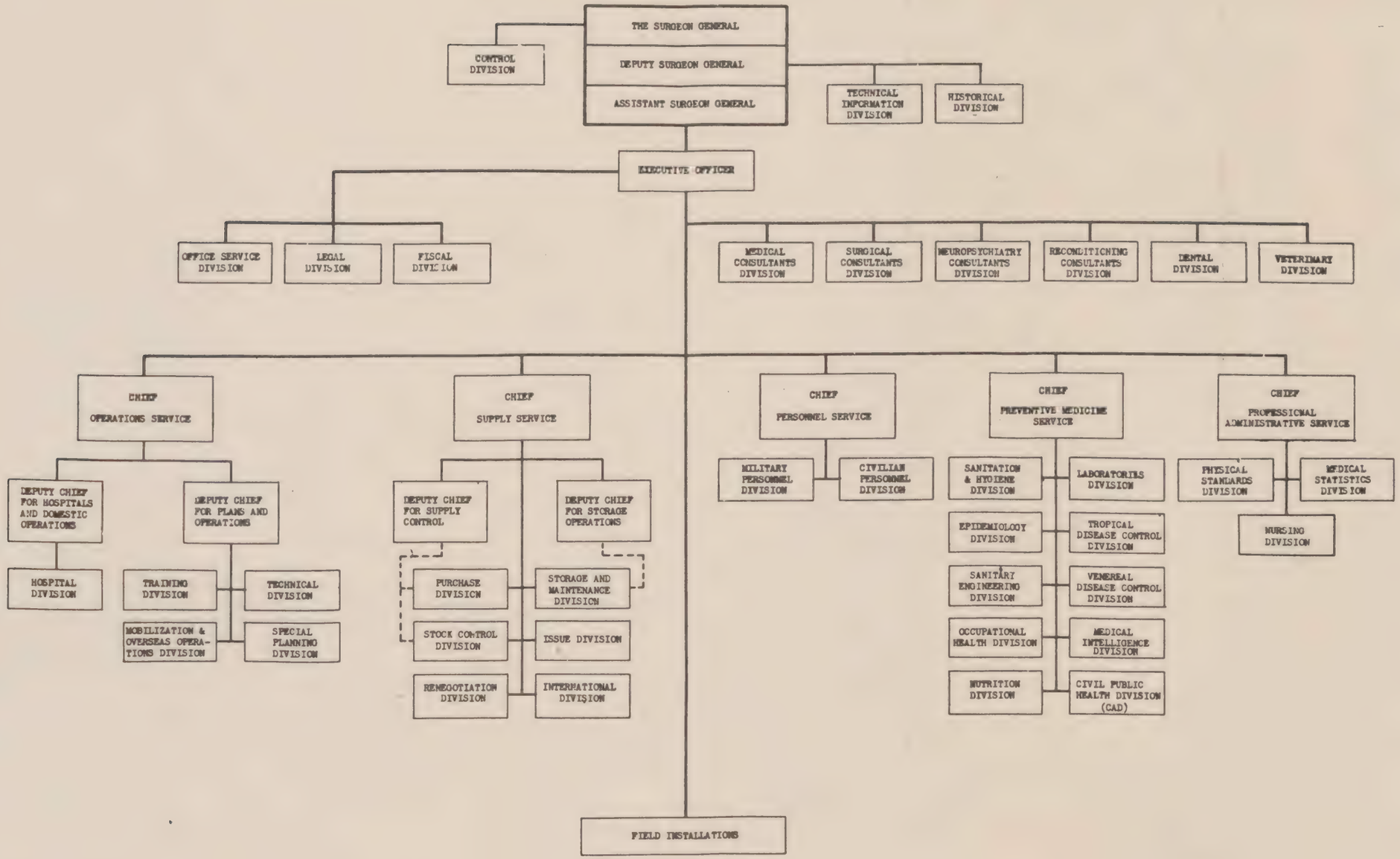


CHART XIV

APPROVED:

NORMAN T. KIRK,
Major General, U. S. Army,
The Surgeon General.

24 August 1944.

duties from advisory functions. This reorganization was the last major change to affect the entire structure of the Office of The Surgeon General.

NOTES ON CHAPTER V

[1]Memorandum from the Director, Control Division, SGO, to The Surgeon General, subject: Interim report on changes in Surgeon General's chart, 3 December 1943 (Control Division, SGO).

[2]Ibid.

[3]SGO Office Order 4, 1 Jan 1944.

[4]Memorandum from the Director, Control Division, SGO, to The Surgeon General, 3 Dec 1943 (Control Division, SGO).

[5]Memorandum for the Director, Historical Division, subject: Annual Report of the Professional Service, 1943-1944, 20 June 1944 (Historical Division, SGO, 319.1-2).

[6]Ibid.

[7]SGO Office Order 4, 1 Jan 1944.

[8]Condensed Report of Activities and Accomplishments of the Preventive Medicine Service for the Fiscal Year 1944 (Historical Division, SGO, 319.1-2).

[9]Ibid.

[10]Memorandum from Director, Control Division, SGO, for General Kirk, subject: Proposal for overall plan for most effective utilization of officer allotment, civilian personnel, and space in The Surgeon General's Office and for modifications in present organization, dated 13 Jan 1944, p. 15 (Control Division, SGO).

[11]Ibid.; also see SGO Office Order 419, 28 Jun 1943 and Office Order 776, 1 Oct 1943.

[12]Memorandum from Director, Control Division, SGO, for General Kirk, see above Note 10, pp. 17-34.

[13]Ibid., pp. 10-14.

[14]Organization Chart, approved 3 Feb 1944 (Chart XIII of this study).

[15]SGO Office Order 84, 19 Apr 1944; Annual Report of the Operations Service 1944, Inclosure 1 (Historical Division, SGO, 319.1-2).

[16]Annual Report of the Operations Service, 1944 (Historical Division, SGO, 319.1-2); Office of The Surgeon General, Manual of Organization and Standard Practices, p. 3.08/7, dated 15 Mar 1944.

[17]SGO Organization Manual, p. 3.08/7, dated 15 Mar 1944.

[18]Ibid., p. 3.08/7, dated 1 May 1944.

[19]Annual Report of the Operations Service (Technical Division), 1944, p. 2 (Historical Division, SGO, 319.1-2).

[20]SGO Office Order 29, 10 Feb 1944.

[21]See Par. 9, War Department Circular 140, 11 Apr 1944; Section II, Army Service Forces Circular No. 147, 19 May 1944; Annual Report of Operations Service (Hospital Division), 1944, p. 12 (Historical Division, SGO, 319.1-2).

[22]Memorandum from Director, Control Division, SGO, for General Kirk, subject: Proposal for . . . modifications in present organization, dated 13 Jan 1944, p. 16 (Control Division, SGO).

[23]Annual Report of Operations Service (Hospital Division), 1944, p. 1 (Historical Division, SGO, 319.1-2).

[24]Annual Report, Resources Analysis Division, 1945, p. 2 (Historical Division, SGO, 319.1-2); SGO Office Order 208, 23 Oct 1944.

[25]SGO Office Order 175, 25 Aug 1944; Office Order 208, 23 Oct 1944.

[26]SGO Office Order 217, 2 Nov 1944.

[27]Annual Report of Operations Service (Hospital Division), 1944, pp. 2-4 (Historical Division, SGO, 319.1-2); SGO Organization Manual, dated 15 May 1944, p. 3.08/5.

[28]Memorandum from the Director, Control Division, SGO, for General Kirk, dated 13 Jan 1944, p. 15 (Control Division, SGO).

[29]Annual Report of the Training Division, SGO, 1944 (Historical Division, SGO, 319.1-2); SGO Organization Manual, pp. 3.08 and 3.08/2, dated 15 May 1944.

[30]Army Service Forces Circular 104, 15 Apr 1944.

[31]Annual Report of the Training Division, SGO, 1944; ASF Organization Manual (301), p. 306.00/12, dated 15 Aug 1944.

[32]Memorandum from Director, Control Division, SGO, for General Kirk, dated 13 Jan 1944, pp. 18-23 (Control Division, SGO).

[33]SGO Office Order 24, 28 Jan 1944.

[34]SGO Organization Manual, pp. 3.07, dated 15 Mar 1944; pp. 3.02, dated 1 May 1944. 1-3
1-3

[35]SGO Organization Manual, pp. 3.09, dated 24 June 1944.

[36]SGO Office Order 111, 26 May 1944.

[37]Set forth in a Secret Communication from the Director, Control Division, SGO, to The Surgeon General, subject: Draft of proposal for changes in Office Organization of SGO, dated 19 June 1944 (Control Division, SGO).

[38]Ibid., p. 3.

[39]Ibid., p. 4.

[40]Secret Memorandum from The Director, Control Division, SGO, to The Surgeon General, dated 17 Aug 1944 (Control Division, SGO).

[41]Ibid., par. 3c.

[42]Ibid.

[43]Par. 2, SGO Office Order 175, 25 Aug 1944.

[44]Ibid., par. 3.

[45]Ibid., par. 4.

[46]Ibid., par. 5 and 6.

[47]Ibid., par. 7 and 8.

[48]Ibid., par. 9.

CHAPTER VI

CONCLUDING WAR-TIME CHANGES IN THE ORGANIZATION OF THE OFFICE OF THE SURGEON GENERAL

The reorganizations of the Office of The Surgeon General in 1944 established the organizational pattern for the remainder of the war. This is shown by the fact that no attempts were made to revise The Surgeon General's Manual of Organization, and only one organization chart was published during the remainder of the war period. This last chart, published in January 1945, does not reach below the division level and reveals no major changes in the structure of the organization. Two additional charts were issued to illustrate post-war developments and a fourth established the adjustment to a peace-time organization. The realignment of functions traced in these later plans will be discussed in the third section of this chapter.

Within the broad pattern of organization, however, major developments were made for the more effective utilization of personnel and for the conduct of research and development activities.

Continued Reorganization of Personnel Activities

We have seen in Chapter V that various changes were made in the organization of the Personnel Service during 1944 to improve the operations of personnel activities in the Office of The Surgeon General. In the main, these improvements were designed to enrich the records of the service, to provide for better planning in the utilization of personnel, and to promote more effective coordination with other services, in order that The Surgeon General could request authority for greater control over Medical Department personnel. The expansion of the service apparently accomplished one desired result, for The Surgeon General obtained authority in May 1944 to assign Medical Corps officers and nurses among the various organizational elements of the Army Service Forces.[1] He was empowered to request or supply key personnel by name for the general and regional hospitals, and to clear all requests for Medical Corps officers through his office before assignment by The Adjutant General. The organization of the Personnel Service, however, failed to provide the most effective machinery to discharge these responsibilities. The Control Division, SGO, was prepared to make a study of the service with a view to increasing its efficiency, when the Personnel Service arranged for an independent study to be made by a civilian agency. The investigation was conducted by representatives of the Industrial Relations Counselors, Inc., during February and March 1945. The results of the study were submitted in a comprehensive Report

on Organization for Personnel Administration in the Office of The Surgeon General,[2] which recommended:

> That the responsibilities of the Personnel Service be definitely determined;
>
> That the personnel administration of all but key specialists should be decentralized to service commands; and that the records now kept in the Office of The Surgeon General for other than key personnel should be eliminated;
>
> That a post of Deputy Chief of the Personnel Service be created and that a Director of the Military Personnel Division separate from the Chief of Personnel be appointed;
>
> That all requisitions for bulk numbers of personnel to be supplied over a period of time belonged to the Operations Service, and that the transfer of records and personnel to accomplish this purpose be made from the Records and Statistics Branch of Military Personnel Division to the Resources Analysis Division, Operations Service;
>
> That a Policy Branch be established;
>
> That Staff Assistants for enlisted personnel and women Medical Department officers be appointed, subordinate to and reporting to the Director of Military Personnel; and
>
> That the Army Nurse, Physical Therapist and Hospital Dietitian Branches, and the Enlisted Section of the Operations Branch be abolished.

The Director of the Control Division, SGO, analyzed the proposals, and, while agreeing with most of them in principle, wrote:

> . . . two main points are raised by the report:
> a. To see that the plan of office order 175 (which established the principle of coordinating all operations activities relating to personnel through the Operations Service) is understood and carried out, and the work of the Military Personnel Division is, under it, properly coordinated with the Resources Analysis Division.
> b. To make a determination as to whether the decentralization to service commands of assignments of other than key personnel is to be fully adopted;

ORGANIZATION CHART
OFFICE OF THE SURGEON GENERAL
ARMY SERVICE FORCES

CHART XV

1 JANUARY 1945

and if so to define key personnel and to adjust records. As to this, it is believed that key personnel should include all specialists, and that complete records of such specialist groups should be maintained here, whereas records on others should be cut to a minimum.[3]

Major changes in organization of the Personnel Service were not made immediately following these reports; but the functioning of the service was greatly altered, and the proposed changes were carefully studied.[4] Two of the recommendations were carried out. The Records and Statistics Branch (formerly Personnel Planning and Placement) surrendered all its requirements studies to the Resources Analysis Division, Operations Service, and plans were developed to merge this branch with the Classification Branch.[5] In addition, a Director was appointed to head the Military Personnel Division.[6]

In September 1945 further reorganizations along the functional lines recommended in the reports were made in the Personnel Service, which included the appointment of a Special Assistant to the Chief of Personnel and three Assistants to the Director, Military Personnel Division. In this intermediate step the personnel of the Enlisted Personnel Section, Operations Branch, and those of the Physical Therapy and Dietitians Branches were transferred to the office of Director, Military Personnel Division, and their chiefs became Assistants to the Director for their respective specialists; the Records and Statistics Branch and the Classification Branch were combined to form the Classification and Records Branch; the Operations Branch, minus the Enlisted Personnel Section, was redesignated as the Assignment Branch; and the increased duties of the Procurement Branch were stressed, and its title changed to Procurement, Separations and Reserve Branch.[7] On 11 October 1945 the division was again reorganized to form the Procurement, Separation and Reserve; Classification and Assignment Operations; and Records Planning and Placement Branches.[8] In March 1946 the division was again regrouped into the Assignments; Classification and Records; Procurement, Separations and Reserve; and Army Nurse Branches.[9]

The problem of adequate personnel control for military personnel within the jurisdiction of The Surgeon General was vigorously attacked, and by the end of the war period, it appears to have been solved. Much of the credit for "policing" The Surgeon General's officer allotment was due to the Personnel Control Branch. In January 1945, following various oral directives from Headquarters, Army Service Forces, a full-time Personnel Control Branch was established in the Personnel Service. This Branch was responsible to The Surgeon General's

Personnel Authorization Board in three major fields:

1. Administering the control of personnel allotments;

2. Maintaining records for authorizations, compiling reports for and maintaining liaison with the Military Personnel Division, Army Service Forces; and

3. Making studies to determine the need for personnel.[10]

In order to accomplish the mission of the branch, four sections were established. The Strength and Authorization Section received authorizations of personnel from Headquarters, Army Service Forces, and in turn established sub-authorizations under the jurisdiction of The Surgeon General. These authorizations continually fluctuated, and constant supervision on the part of the section was necessary in order to remain within established ceilings. A Promotion Section processed all recommendations for promotions of officers in the SGO; and upon approval of The Surgeon General's Promotion Board, indorsed and forwarded them to higher authority. The Unit Personnel Section maintained the personnel records for all officers within the Office of The Surgeon General and prepared all necessary reports relating to these records. The Statistical Section was established to compile all recurring reports directed by higher authority. The branch was also charged with performing the operating functions of the Personnel Authorization Board. In December 1945 the Personnel Authorization Board was delegated The Surgeon General's executive power to make and modify personnel authorizations. At this time the Personnel Control Branch was reconstituted to form a Personnel Control Unit and placed under the direct authority of the Executive Officer, SGO, in order to carry out the service functions of the board.[11]

During 1945 the responsibilities for readjustment and redeployment planning devolved in part upon the Personnel Service. The actual planning was coordinated in the Special Planning Division, Operations Service, but many details concerning requirements and availabilities were worked out by the Personnel Service and the Resources Analysis Division, Operations Service. All policies relating to the separation of Medical Department personnel were likewise joint responsibilities.[12] One phase of this problem led to the establishment of a board to formulate policies concerning the relief of Medical Department personnel, in order to determine the essentiality of Medical Department officers in the Army Service Forces who were seeking separation from the

ORGANIZATION CHART

OFFICE OF THE SURGEON GENERAL
ARMY SERVICE FORCES

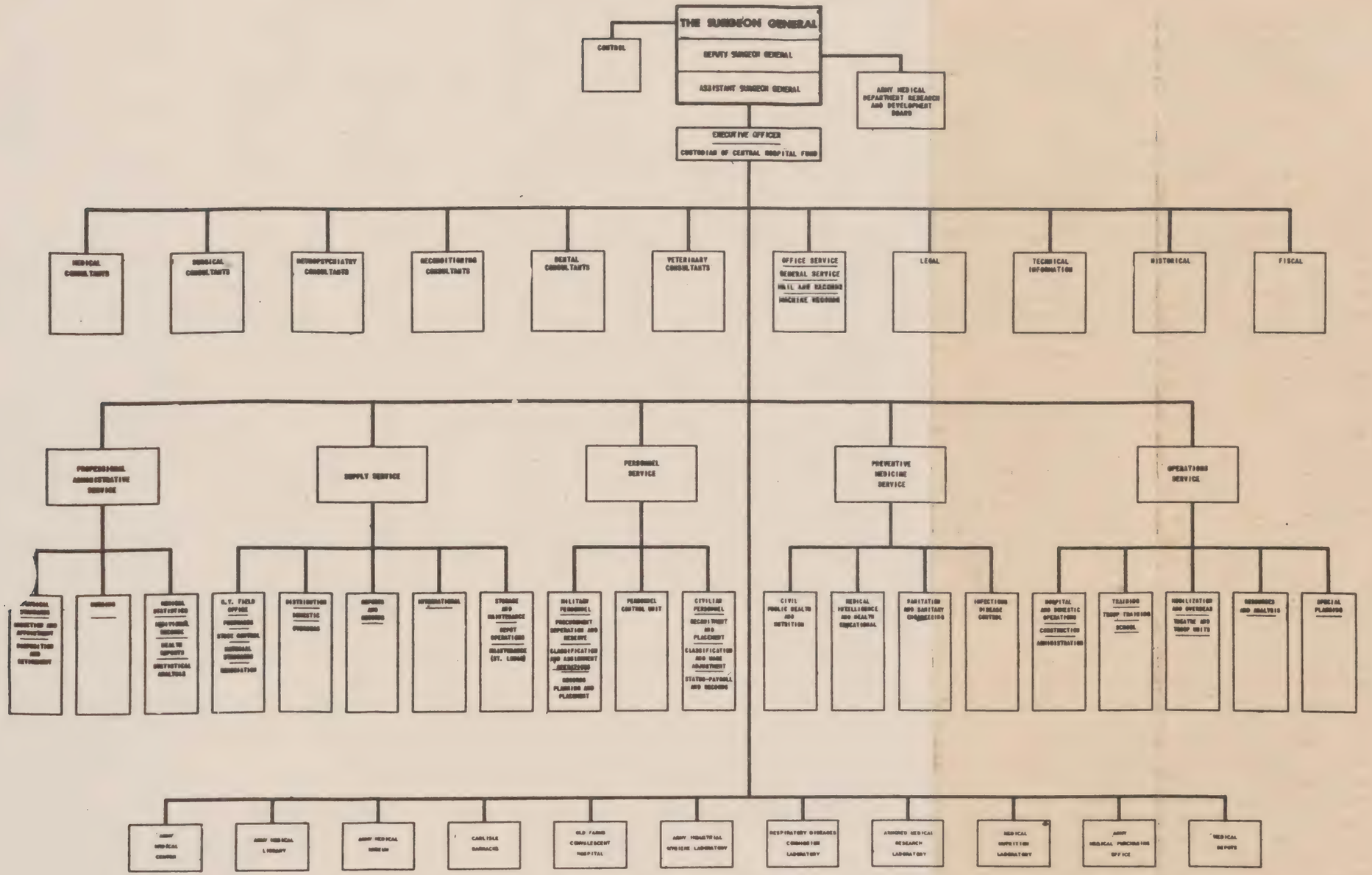
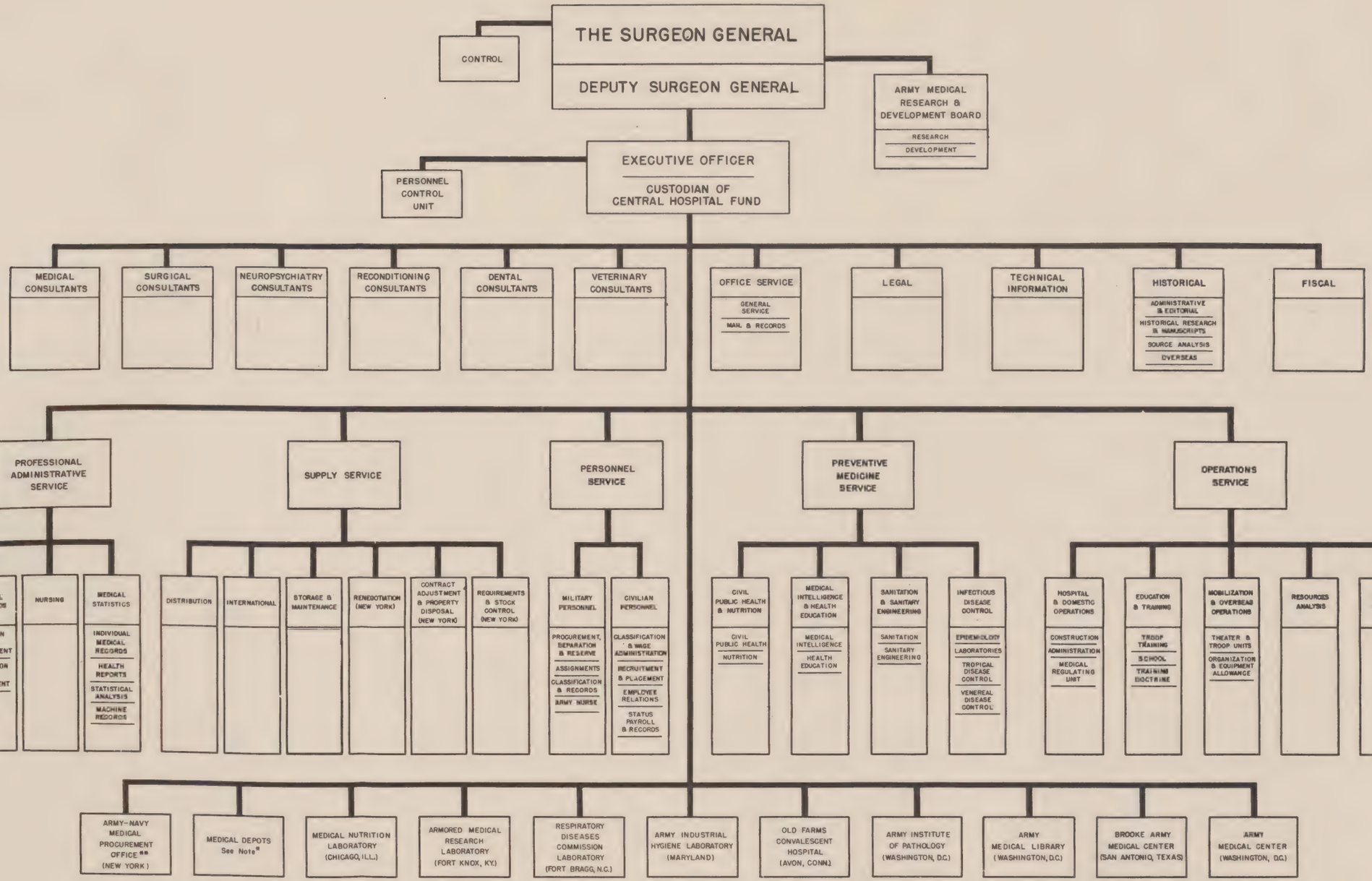


CHART XVI

11 OCTOBER 1945

OFFICE OF THE SURGEON GENERAL



* MEDICAL DEPOTS: BINGHAMTON (NY), DENVER (COLO), LOUISVILLE (KY), ST. LOUIS (MO) AND SAN FRANCISCO (CALIF).
MEDICAL SECTIONS OF ASF DEPOTS: ATLANTA (GA), COLUMBUS (OHIO), SAN ANTONIO (TEXAS), SEATTLE (WASH), LATHROP (CALIF) AND RICHMOND (VA).

** THIS ACTIVITY IS UNDER THE JOINT TECHNICAL SUPERVISION OF THE SURGEON GENERALS OF THE ARMY AND THE NAVY.

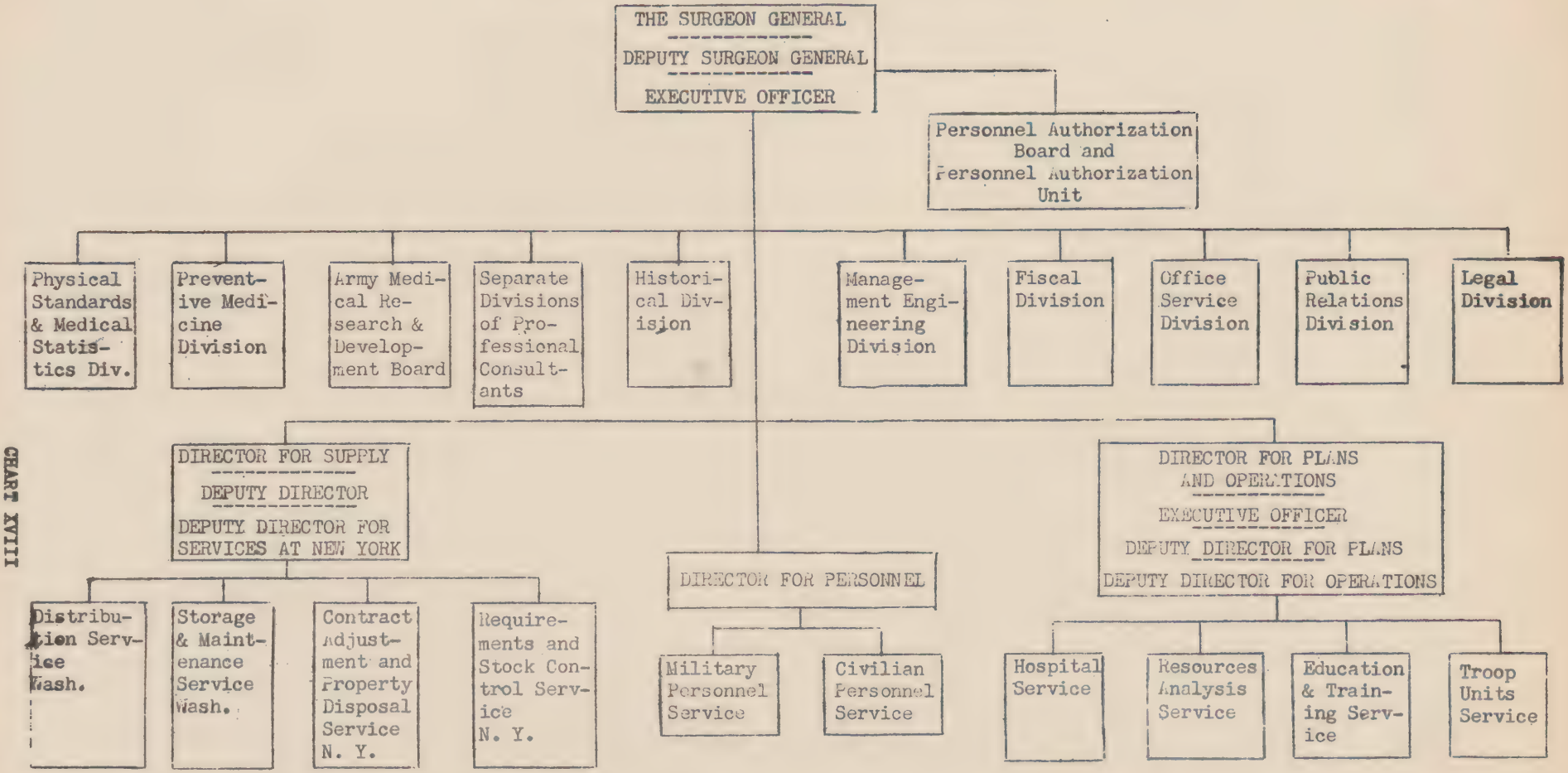
MAJOR GENERAL, U.S. ARMY
THE SURGEON GENERAL
25 MARCH 1946

CHART XVII

ORGANIZATION CHART - OFFICE OF THE SURGEON GENERAL

May 1946
Chart 1

CHART XVIII



Attached charts show division details. Statements of missions and functions are being prepared and will be issued in a revision of the Surgeon General's Manual.

service. The board, composed of members representing the three major commands, was considered essential for redeployment planning.[13]

The Reorganization of Research and Development Activities

The merger of supply planning, research, and development activities in the Technical Division, Operations Service, had been regarded as a major forward step when it was set into operation in February 1944. Basically this merger was sound in principle. For a while it worked according to plan and was regarded as a highly satisfactory arrangement. Serious difficulties, however, arose with the Supply Service during the latter part of 1944 and early in 1945, especially as to the Supply Service's negotiations with the Navy in connection with the joint procurement program.[14] Because of these difficulties, The Surgeon General directed that a through study be made in order to determine the reasons for the imbroglio. In order to conduct this survey, an officer who possessed both supply and operations experience was obtained to study the situation. During the course of this study, it became evident that there was no clear border line between research and development activities, and further, that to prevent jurisdictional difficulties and delays, an over-all board should be established which would provide for one officer who would devote his full attention to research and another officer who would be made responsible for all development projects. This board should be small enough to assure a working group, but large enough to allow representation of the principal services and divisions of the Office of The Surgeon General. It was clear that such a board would bisect the responsibilities of the various services and divisions, and could not, therefore, be placed logically in any one of them. It was further believed that the unit should be on a high organizational level and should report directly to The Surgeon General, the Deputy Surgeon General, or the Assistant Surgeon General. The study revealed that the existing Technical Division was not an integrated organization for the initiation, supervision of, or maintenance of contact with, research and development projects. It was considered of the utmost importance that the full-time officers and other members of the board should be men with a particular flair for research or development work, and that the program should be backed by sufficient officer and civilian allotments to adequately discharge the responsibilities of The Surgeon General in these fields. It was felt that such allotments would result from the recommended dissolution of the Technical Division and the physical transfer of development functions to New York City. As a result of these observations, a series of recommendations for a radical reorganization of research

and development activities was reported to The Surgeon General on 31 May 1945.[15] The Surgeon General approved the proposals, but directed that certain modifications be made, primarily to assure adequate attention to clinical research. These modifications were incorporated into the original proposals,[16] and the entire plan was set forth in an office order on 17 August 1945.[17] The order established an Army Medical Research and Development Board directly responsible to The Surgeon General.[18] The Board was charged with responsibility for the conduct of Medical Department development activities, and, further, would exercise its powers to supervise and coordinate all Medical Department research activities through the chiefs of services and directors of divisions in the Office of The Surgeon General. The Army Epidemiological Board would hereafter function under the general supervision of the Army Medical Research and Development Board. The new board was organized into a Research Division and a Development Division. The latter division was to be physically located in New York City and attached to the Army Medical Purchasing Office, with a Liaison Branch in Washington. The Medical Department Equipment Laboratory at the Medical Field Service School (Carlisle Barracks) was placed, through the Director of the Development Division, under the control and supervision of the Board. Membership of the Board consisted of a full-time chairman; the Director, Development Division; the Director, Research Division, who also acted as secretary; the Chief, Preventive Medicine Service; the Directors of the Medical Consultants, Surgical Consultants, and Neuropsychiatry Consultants Divisions; the Air and Ground Surgeons; and the President of the Epidemiological Board. In addition the Chairman of the Division of Medical Science, National Research Council, and the Chairman of the Committee on Medical Research were to be invited to membership on the Board, and the Directors of the Dental and Veterinary Divisions were to be included in all matters concerning these fields.

Authority to act for The Surgeon General was vested in the entire Board or through an Executive Committee composed of the first five above-named members. In September 1945 the Chief of the Supply Service was added as a member of both the Board and the Executive Committee.[19]

To perform the mission of the Board, consultants were to be appointed and investigating groups were to be established for special research activities. The Medical Department Technical Committee was reorganized, and, henceforth, would function under the control of the Army Medical Research and Development Board. This committee included the principal members of the Board in addition to representatives of other major commands and technical services.

Concurrently with the establishment of the Army Medical Research and Development Board in August 1945, the Technical Division of the Operations Service was dissolved;[20] and the personnel of the unit was assigned to the Research and Development Divisions of the Board, the Liaison Branch of the Supply Service, and the Mobilization and Overseas Operation Division, Operations Service.[21] This arrangement for the conduct of Medical Department research and development activities continued without change through the reorganization of the Office of The Surgeon General on 25 March 1946 (See Chart XVII).

Concluding Changes in Organization

The last plan published to show the organization of the Office of The Surgeon General during the war was dated 1 January 1945 (See Chart XV). This chart was limited to the division level. It was not accompanied by the usual office order which had previously authenticated such charts. No changes are made in independent divisions in this diagram, and only two changes had taken place within the organization of the services since the last chart was published in August 1944. The Resources Analysis Division now appears as a separate division for the first time directly under the control of the Chief of Operations Service. It will be recalled from the discussion in Chapter V that this division was established in October 1944.[22] The January 1945 Organization Chart deleted the Deputy Chief for the Supply Service. This was probably due to a change which took place in the Stock Control Division, for in November 1944, the Stock Control Division was enlarged and transferred to the Army Medical Purchasing Office, leaving only the Requirements Branch of the division in Washington.[23]

In the nine-month interval between the publication of this chart and that of 11 October 1944 (See Chart XVI),[24] some revisions were made which should be noted.

On 5 April 1945 all operational phases of the convalescent reconditioning program in the Zone of the Interior were transferred to the Operations Service from the Reconditioning Consultants Division.[25] The Reconditioning Division continued to act as consultant on all matters of policy. The responsibility for the supervision of all operational phases was delegated by the Chief of Operations to the Director, Hospital Division.[26] Special assistants were then assigned in the Hospital Division to supervise an enlarged program, which included the development of exploratory pre-vocational courses adapted to patient interests, aptitudes, and employment possibilities; the introduction of special reconditioning programs for amputees; and a complete revision of the reconditioning training program for patients in regional and station hospitals.[27]

During the spring of 1945, the movement of units of the Supply Service to New York continued. In March the Catalog Branch, Office of the Chief, was transferred to New York. This was followed in July by the movement of the Requirements Branch, Supply Control Division. "Shortly before the German surrender in May 1945, plans were made to move other parts of the Supply Service to the Army Medical Purchasing Office, but these plans were abandoned when it became apparent that the procurement and distribution programs would be sharply curtailed."[28]

The movement of many units of the Supply Service to New York necessitated a change in the organization of the Control Division, SGO, in order to regulate the management and organization of the Army Medical Purchasing Office. In the attempt to provide for these functions, the Control Division was bifurcated. The Control Division, SGO, was delegated the responsibility for all control matters, except for the Supply Service. A Control Division for Supply Service was established which would exercise all control responsibility for supply in the Office of The Surgeon General, the Army Medical Purchasing Office, and the depots. The Director of the Control Division in AMPO was regarded as on attached service.[29] This scheme of divided authority failed to work out satisfactorily, and the plan was later abolished. A Control Officer for the Control Division, SGO, was attached to the Army Medical Purchasing Office and assigned the functions formerly exercised by the Control Division for the Supply Service.[30]

The end of the war in Europe reduced the need for a large planning unit in the Operations Service and led to a reorganization of the service. The positions of Deputy Chief for Operations and Deputy Chief for Hospitals and Domestic Operations were abolished. The Theater Branch and the Troop Units Branch of the Mobilization and Overseas Operations Division were consolidated into a Theater and Troop Units Branch, although the division was maintained. The work of the latter branch was delegated to the Theater, Troop Units, and Reports Sections. This reorganization practically abolished the Inspection Branch of the Operations Service.[31] The activities of the Civil Affairs Branch, Special Planning Division, were transferred to the International Division, Supply Service, on 24 September 1945.[32] This was a logical move, for the planning stage had now passed; and the entire emphasis had shifted to the actual delivery of the supplies.

The reduced size of the Army and the corresponding reductions in training needs led to a reorganization of the Training Division. The Readiness and Requirements Branch was dissolved, and the Regular Training Branch was redesignated as the Troop Training Branch. The new branch absorbed

the functions of both branches. The School Branch was reorganized into Curricular, Requirements, and Special Training Sections.[33]

The organization of the Office of The Surgeon General on 11 October 1945 incorporated all these changes and set forth additional readjustments. The Army Medical Department Research and Development Board appears for the first time as an activity directly under the supervision of The Surgeon General. The Technical Information and Historical Divisions were placed on the same general level as other separate divisions, and the Dental and Veterinary Divisions became the Dental and Veterinary Consultants Divisions. The Preventive Medicine Service was shrunk to four divisions which included: the Civil Public Health; Medical Intelligence and Health Education; Sanitation and Sanitary Engineering; and Infectious Disease Control Divisions.

The Supply Service consisted of the New York field office which was composed of the Purchases, Stock Control, Material Standards, and Renegotiation Divisions; the Distribution Division, divided into the Domestic and Overseas Branches; the Reports and Records Division; the International Division; and the Storage and Maintenance Division.

In the Professional Administrative Service, the Physical Standards Division was functionally divided into the Induction and Appointment Branch and the Disposition and Retirement Branch. No changes were made in the Nursing or Medical Statistics Divisions.

The organization chart of 25 March 1946, promulgated by office order 102, reveals that only minor changes had been made in the five-month interval following the October 1945 plan. It altered the status of the Personnel Control Unit, as already noted. No important change took place in the separate divisions. The Office Service Division restored the Machine Records Branch to the Medical Statistics Division of the Professional Administrative Service.[34] On the service level, the Supply Service eliminated the Reports and Records Division and transformed it into a branch;[35] and the Operations Service reclaimed the Medical Regulating Unit. This unit had always been an activity of the Deputy Chief for Hospital and Domestic Operations, Operations Service, but since its establishment had been physically located in the Office of The Chief of Transportation.

The changes in March 1946 did not materially affect the organizational structure of the Office of The Surgeon General. They did, however, complete the changes in the organization for the war years. A later revision of the

entire structure in May and June 1946 will, perhaps, establish the organizational pattern for the peace-time Army. This organization has not been completed at this time, (June 1946) and a discussion of its many interesting elements properly belongs to another study.

NOTES ON CHAPTER VI

[1]Army Service Forces Circular 138, 12 May 1944.

[2]Report from Industrial Relations Counselors, New York City, 34 pp., submitted to The Surgeon General, 4 April 1945 (Control Division, SGO).

[3]Director, Control Division, SGO, Comment of Control Division on Report from Industrial Relations Counselors, Inc., 26 Apr 1945 (Control Division, SGO).

[4]Memorandum from the Deputy Chief, Personnel Service, for Historical Division, SGO, subject: History for the Deputy Chief, Personnel Service, from period covering 1 January to 10 Jun 1945, 8 Jun 1945 (Historical Division, SGO).

[5]Quarterly Report, 1 April - 31 May 1945, Records and Statistics Branch, Military Personnel Division, p. 3 (Historical Division, SGO).

[6]Quarterly report of activities, Operations Branch, Military Personnel Division, for the period 1 April to and thru 10 June 1945 (Historical Division, SGO).

[7]Personnel Service Memorandum No. 1, 14 Sep 1945.

[8]SGO Office Order 271, 18 Oct 1945; See Chart XVI.

[9]SGO Office Order 102, 21 Mar 1946; See Chart XVII.

[10]Annual Report of the Control Division, 1945, p. 26 (Historical Division, SGO).

[11]SGO Office Order 344, 3 Dec 1945; Charts XVII and XVIII.

[12]Annual Report of the Control Division, 1945, dated 25 Jun 1945, p. 25 (Historical Division, SGO); SGO Office Order 88, 20 Apr 1945.

[13]History of Deputy Chief, Personnel Service, 8 Jun 1945 (Historical Division, SGO); SGO Office Order 105, 11 May 1945.

[14]These negotiations ultimately led to the establishment of a joint Army-Navy Medical Material and Specifications Board. See Memorandum from under Secretary of War and Assistant Secretary of the Navy for CG, Army Service Forces and Surgeon General of the Navy, subject: Joint Procurement of Medical and Surgical Equipment and Supplies, 21 May 1945. Copy in Annual Report, Technical Division, Operations

Service, SGO, 9 Jun 1945 (Historical Division, SGO, 319.1-2); Annual Report of Control Division, SGO, 23 Jun 1945, p. 28 (Historical Division, SGO, 319.1-2).

[15]Memorandum from Control Division, SGO, for The Surgeon General, subject: Study of Research and Development Activities and Organization, Office of The Surgeon General, dated 31 May 1945 (Control Division, SGO).

[16]Memorandum from Control Division, SGO, for The Surgeon General, subject: Supplement to basic study, dated 2 Jul 1945 (Control Division, SGO); Memo for record, subject: Plan for Army Medical Research and Development Board, 4 Jul 1945 (Control Division, SGO); Director, Control Division, Notes on discussion of 23 Jul 1945 concerning Research and Development Organization, and Summary of Present Status of Proposals, dated 27 Jul 1945 (Control Division, SGO).

[17]SGO Office Order 194, 11 Aug 1945.

[18]An earlier proposal had indicated that the Assistant Surgeon General would exclusively supervise the organization of the Board and that it would report directly to him. See: Memorandum by Director, Control Division, for file, subject: Research and Development, dated 18 Jul 1945 (Control Division, SGO).

[19]SGO Office Order 260, 28 Sep 1945.

[20]SGO Office Order 195, 17 Aug 1945.

[21]SGO Office Order 221, 1 Sep 1945.

[22]SGO Office Order 208, 23 Oct 1944.

[23]Yates, opus cited, p. 60.

[24]The provisions of the chart were made effective by SGO Office Order 291, 18 Oct 1945.

[25]SGO Office Order 72, 5 Apr 1945.

[26]Memorandum from Chief, Operations Service, SGO, to Director, Hospital Division, 3 Apr 1945 (Hospital Division, SGO).

[27]Memorandum from the Director, Hospital Division, for the Chief, Operations Service, SGO, subject: Annual Report for the Fiscal Year 1945, 9 June 1945, pp. 3-5. (Historical Division, SGO 319.1-2).

[28]Yates, opus cited, p. 60.

[29]SGO Office Order 197, 17 Aug 1945.

[30]SGO Office Order 327, 23 Nov 1945.

[31]SGO Office Order 256, 26 Sep 1945.

[32]SGO Office Order 246, 20 Sep 1945.

[33]SGO Office Order 294, 22 Oct 1945.

[34]SGO Office Order 330, 26 Nov 1945.

[35]Despite the organizations of the Reports and Records Division, set forth in office order 291, 1945, this unit actually continued to operate as a branch directly under the Chief, Supply Service. Office order 102, 25 March 1946, confirmed its status.

Pages 77 - 78 missing

certain functions performed "directly," as the first manual (30 September 1942) described them.[7] Later these were divided into two categories designated "headquarters operating functions" and "field operating functions." According to the first list (1942). The Surgeon General's Office

(a) Based upon investigative studies and records of disease prevalence in all parts of the world, determines upon and supervises the vaccination, inoculation, and other protective measures required by military personnel. [The grammar is cloudy but the meaning is clear enough.]

(b) Determines upon and supervises the sanitary measures to be enforced in all localities where troops are located.

(c) Supervises the health inspection of meat, meat food, and dairy products to be consumed by troops.

(d) Supervises professional treatment methods (medical, surgical, dental, nursing, and veterinary) throughout the United States.

(e) Supervises the distribution of patients in Army Hospitals.

(f) Conducts a program of venereal disease control in troop areas.

(g) Conducts a program of industrial hygiene and prevention of health hazards in Army controlled industrial plants.

(h) Supervises the operation of the Army Medical Center, Washington, D.C., including the professional services and enlisted specialist schools, and the Walter Reed General Hospital.

(i) Supervises the operation of the General Dispensary, U.S. Army, Washington, D.C.

(j) Supervises the operation of the Army Medical Library.

(k) Supervises the operation of the Army Medical Museum.

(l) Compiles records of vital statistics of the Army.

(m) Supervises operation of procurement districts through which medical supplies and equipment are procured and inspected.

(n) Supervises the operation of medical depots.

(o) Makes periodical inspection of storage activities at medical depots to insure that War Department policies are carried out.

(p) Maintains and repairs buildings and utilities at medical depots and installations.

Except for the omission of items "i" and "p" and the addition of two other functions the list remained unchanged during the rest of the war. The manual for 1 October 1943 added: "Supervises the operation of the Army Medical Hygiene Laboratory" and "Supervises the operation of the Medical Department Equipment Laboratory and the Medical Department Field Service Schools at Carlisle, Pa."

This gives some idea of the wider reaches of The Surgeon General's authority as well as its relation to specific field installations after the middle of 1942. The installations mentioned had not all existed since the beginning of the war, however, and some had had a different status with respect to the Office of The Surgeon General or to one another during the earlier war period. This will be considered when we discuss the various installations individually.

Moreover, merely to say that the Office of The Surgeon General exercised certain kinds of authority or "supervised" or "commanded" certain installations does not indicate how this authority was exercised. It might be an almost nominal oversight or, on the other hand, a very close supervision. It might be exercised mainly by one part of the office or by several parts; central agencies such as those concerned with personnel control, supply, and planning would have something to do with all or most of the field installations; others would have more limited contacts in the field. Here again some of these variations will appear when the installations are dealt with separately. Finally, in the case of the Army-Navy Medical Procurement Office at New York, created toward the end of 1945, The Surgeon General's authority was exercised jointly with that of The Surgeon General of the Navy.[8]

The field installations of The Surgeon General's Office may be divided into several groups: (1) those providing mainly hospital and medical service, (2) those engaged in education and research, and (3) those concerned with finance and supply. The composition of each group varied from time to time as old agencies disappeared and new ones were instituted.[9] In considering the relation of these groups to the Office of The Surgeon General, it must be remembered that almost any element of that office might have something to do

with any one of the groups. However, only those elements will be dealt with whose contact with the particular groups was apt to be most constant or direct. For this purpose the period covered will be mainly 1942-1946, beginning when the wartime structure was first outlined in the organization manuals and continuing to the present writing.

Field Installations for Hospital and Medical Service

The field installations which performed mainly hospital or other medical service included, at one time or another during the war period, the general hospitals, one or more convalescent hospitals, the hospital centers, and the General Dispensary at Washington, D.C. From July 1942 to April 1946, the general hospitals (except Walter Reed) were removed from the direct jurisdiction of The Surgeon General's Office and transferred to that of the service commanders. The convalescent hospitals (except Old Farms at Avon, Conn.) did not come under the direct control of The Surgeon General until the latter date. The General Dispensary at Washington ceased to be a field installation of The Surgeon General when it was transferred to the command of the Military District of Washington on 1 February 1943.[10]

A number of branches and divisions of The Surgeon General's Office were specially concerned with hospitals and medical service. None of these agencies, however, devoted themselves exclusively to the field installations; their influence in such matters extended to all Army units whether or not the latter happened to be under the immediate control of The Surgeon General. One category of subjects with which these central organs dealt was professional care or medical practice. Thus in 1942 there existed in The Surgeon General's Office a Medical Practice Division composed of surgery, medicine, neuropsychiatry, and nutrition branches, a Dental Service Division, a Veterinary Division, a Preventive Medicine Division, and a Nursing Division.[11] Their general function was to establish policies and procedures in these matters and to exercise general supervision over actual practice throughout the Army. The tendency was to expand this central organization or at any rate to multiply its functions and to specialize its parts. By 1944 a Reconditioning Division had been added, and numerous subdivisions made their appearance in almost every field; the Surgical Division alone, for example, by that had no less than six branches—General Surgery, Orthopedic, Transfusion, Radiation, Ophthalmology, and Otolaryngology.[12] Still later in 1944 a number of Consultants Divisions were set up for medicine, surgery, neuropsychiatry, reconditioning, dentistry, and veterinary medicine. This represented a separation of the strictly professional from the administrative side of these services, the administrative aspect now being dealt with for certain

purposes in the Professional Administrative Service. It is not the purpose here to recapitulate the growth of central organization, which has been described in previous chapters, but to indicate the growing minuteness with which every aspect of medical practice in the field installations (as well as outside them) was being scrutinized and regulated from the center.

Other spheres of action at Headquarters affecting the hospital service of field installations were those relating to (a) hospital construction, maintenance, and repair, and (b) hospital administration.

(a) The Hospital Construction Division of 1942, with its several branches, "plans and estimates required construction, additions, renovations, and installed equipment for all Army hospitals," and "secures and distributes funds required for maintenance and repair of medical facilities." In addition it supervised the selection of sites and made inspections of hospital installations for the above purposes.[14] In 1943 the division merged with the Hospital and Evacuation Division to form a Hospital Administration Division.[15]

(b) Hospital administration was dealt with in 1942 by several Headquarters agencies. The Hospital Fund Branch supervised the various local hospital funds; it continued to do so throughout the war, although it was shifted from the Office Administration Division ultimately to the Office of The Surgeon General's Executive Officer.[16] The Vital Records (later Medical Statistics) Division collected and coordinated records of sick and wounded and compiled statistics relating to the health of the Army.[17] These activities remained the same during the rest of the war. They were of course dependent in part on reports from the medical field installations. The Hospital and Evacuation Division, as it existed in 1942, "develops and promulgates policies governing the hospitalization of military personnel and has advisory supervision of hospital administration." This included regulating the flow of patients into general hospitals, a function of the Bed Credits and Evacuation Branch.[18] In 1944 these functions, or similar ones, were in the hands of the Hospital Division and its newly-named branches. The Hospital Division, or Hospital Administration Division as it was formerly called, had already (1943) assumed the duty of supervising construction.[19]

Field Installations for Education and Research

As in the case of the field installations which provided hospital and medical services, those engaged in education and research varied in number and character during

the war period. So far as education, or training, is concerned, the subject has been dealt with more fully elsewhere,[20] and need only be summarized here.

Aside from various isolated medical courses and apprenticeships set up at certain medical installations, a number of organized medical schools and training centers were established before and during the war. Separate training establishments existed throughout the war for enlisted men, prospective officers, and commissioned officers. For enlisted men there were Medical Department Replacement Training Centers (later called Medical Replacement Training Centers and finally Army Service Forces Training Centers),[21] providing basic and "common specialist" training; enlisted technicians' schools; a Medical Supply Service School; and a School for Physical Reconditioning Instructors. For prospective officers there were the Medical Administrative Corps Officer Candidate Schools. For commissioned officers there were a variety of establishments providing specialized training (such as the Medical Field Service School at Carlisle Barracks, Pa.) and advanced professional instruction in medicine (at the Medical Department Professional Service Schools, Army Medical Center, Washington, D.C.).[22]

The Surgeon General's authority over these medical training centers and schools remained stable in one respect during the entire war period: from his office emanated much of the training doctrine, programs, guides, and materials that were employed in the medical instruction of troops. These as well as certain administrative functions were performed at first by the Training Subdivision of the Planning and Training Division; in February 1942 Training became a separate division and continued as such during the remainder of the war. In course of time there were periodic redistributions of functions, or at least of names, among the various branches of the Training Division. A School Branch however continued to exist from 1942 onward. It "formulates, directs, and coordinates policies and plans for the operation of the special service and enlisted technical schools of the Medical Department and the Medical Administrative Corps Officers Training Schools; formulates policies and coordinates, supervises, and inspects the technical training of commissioned and enlisted Medical Department personnel in military installations and civilian educational and vocational institutions; coordinates the conduct of professional and technical training in hospitals." Other branches of the Training Division formulated doctrine and supervised the preparation of training publications, planned the establishment of medical training centers, and inspected their activities. The School Branch and certain other branches also made recommendations with regard to overhead personnel.[23]

In matters other than training doctrine and its propagation, the authority of The Surgeon General over schools and training

centers varied considerably from time to time and from place to place. Those which were of the nature of field installations (responsible to The Surgeon General) were of course most completely under his jurisdiction, and it is with these that we are here concerned. Strictly speaking none of the schools and only briefly the training centers were, in themselves, field installations of The Surgeon General's Office. Thus the Medical Field Service School was only a part although the most important part, of such an installation—namely, Carlisle Barracks, which also included among other activities the Medical Department Equipment Laboratory and, for a time (1941-1943), an Officer Candidate School. The whole post was at first a field installation of The Surgeon General. On 10 August 1942 it was transferred to the control of the Third Service Command as part of a general policy which placed under the service commands all "replacement training centers, unit training centers, and schools." Promulgation of training doctrine and programs, conduct of training and (until 14 April 1943) the selection, assignment, and promotion of faculty personnel, however, remained with The Surgeon General, acting as the agent of the Commanding General, Services of Supply. This arrangement lasted only nine months; on 12 May 1943 Carlisle Barracks was restored to the jurisdiction of The Surgeon General on the same terms as any other Class IV installation.[24]

Toward the end of 1945 it was decided to move the Medical Field Service School to Fort Sam Houston, Tex., where Brooke Medical Center was located, to take advantage of the better winter climate, larger training areas, and the proximity of other Army facilities to that place. In answer to a letter expressing doubt whether the freedom of the School could be maintained in the new location, the Deputy Surgeon General sought to allay this fear and incidentally commented on the administrative situation at Carlisle Barracks during the war period. "The independence which we have enjoyed at Carlisle," he said,

> is important to preserve in any activity. This was one of the first considerations when the move was contemplated. The Surgeon General is satisfied that a Class IV activity at Fort Sam Houston, which has been assured, will permit every bit as much freedom of action as prevailed at Carlisle. As a matter of fact, the past four years housekeeping activities and personnel problems at Carlisle have been much involved with the Service Command. For instance, the Post Hospital was not under The Surgeon General but under the Service Commander, as were many other activities. We will still have this situation to a certain extent at Fort Sam Houston, but not to any degree greater than at Carlisle, and we understand that general hospitals will be under The Surgeon General,[25]

On 15 February 1946 the Medical Field Service School was discontinued at Carlisle Barracks and reestablished within Brooke Medical Center, which had become a field installation of The Surgeon General's Office two weeks before.[26]

Like the Field Service School, the Medical Department Professional Service Schools were part of a Medical Department field installation, in this case the Army Medical Center, which also comprised Walter Reed General Hospital. Its status remained unchanged throughout the war and afterward. The Commander of the Center was also the Commandant of the Schools. (It should be mentioned that a similar arrangement prevailed at all Medical Department schools except those for "common specialists"—the commander of the post or installation to which it was attached was also commandant of the School.)[27] In addition there was an Assistant Commandant for the Center's Schools (Medical, Dental, and Veterinary), each of which had its own director. During most of the war period an Enlisted Technicians' School formed part of the group.[28]

The Field Service and Professional Service Schools were major parts of the installations to which they belonged. The Medical Supply Service School and the various Medical Department enlisted technicians' schools, on the other hand, were more like added activities at installations created for other purposes. Thus the Medical Supply Service School, dating from February 1942, was established at the St. Louis Medical Depot, a Surgeon General's field installation throughout the war. Most of the enlisted technicians' schools were located at general hospitals, all but one of which passed from the control of The Surgeon General to that of the service commanders in August 1942, not to return until April 1946.[29]

The medical replacement training centers showed less consistency than the schools in their relations with higher administrative authority. The first three centers, established in 1941, were at the outset under corps-area jurisdiction. In December 1941 they became field installations ("exempt stations") of The Surgeon General. A fourth center (at Camp Robinson), organized in January 1942, was placed under the Chief of Infantry (later Commanding General, Army Ground Forces) for administration and under The Surgeon General for training purposes.[30] In August 1942 all training centers were transferred to service command control, except for promulgation of training doctrine and programs, conduct of training, and (for a time) the selection, assignment, and promotion of the training staff. In April 1943 the last function was also vested in the service commands.[31] This remained the distribution of authority until the training centers were discontinued.

Turning from field installations concerned with education or training to those engaged in medical research, we may note

that not only training but research was conducted in the Medical Field Service School and the Medical Department Professional Service Schools.[32] A number of laboratories, however, devoted themselves entirely to research, while the Army Medical Library, with its branch depository in Cleveland, and the Army Medical Museum (recently renamed the Army Institute of Pathology) supplied materials for research. The Museum also conducted research in its own collections.[33]

The Library and Museum were at first administered as parts of The Surgeon General's Office, as already noticed.[34] On 1 July 1942, owing to a change in the allocation of funds, "all civilian employees, supplies, and equipment of [the two establishments] will be transferred from the Departmental to Field status, under the supervision of the Librarian, Army Medical Library, and the Curator, Army Medical Museum."[35] Apparently this did not make them precisely field installations, at least in the view of the Personnel Service, for over a year later (18 November 1943) we find the Chief of that Service requesting Headquarters, Army Service Forces, to designate them Class IV installations. "These installations," he wrote,

> physically located in the Military District of Washington, to all intents and purposes are now functioning as Class IV installations under the direct control of The Surgeon General, except for allotment of personnel. Enlisted men assigned to the Army Medical Museum are on a detached service status from the Army Medical Center. Civilian personnel is furnished from the allotment for Field Installations, Military District of Washington. Officer personnel is furnished from the allotment established for The Surgeon General's Office.

The designation of these activities as Class IV installations, he said, would simplify their administration and permit greater flexibility in personnel control.[36] The request was granted on 29 January 1944, when the Library and Museum were named Class IV installations under the control of The Surgeon General.[37] The result, so far as the Library was concerned, was "definitely more administrative responsibilities and . . . a great increase in the compilation of reports."[38]

With the reorganization of the War Department in May and June 1946 the Library and Museum became Class II installations, still under The Surgeon General's jurisdiction. The Museum had been renamed the Army Institute of Pathology on 18 April 1946.[39] An ambiguous statement in an Army Regulation of 7 June 1946, describing the Institute as "an activity of the Office of The Surgeon General," should not be interpreted as affecting its status as a Class II installation.[40] Relations between the Office of The Surgeon General on the one hand and

the Library and Museum on the other were, after 22 October 1945, conducted through the Hospital and Domestic Operations Division, which was charged with coordinating and supervising all their activities. This division, in effect, assumed as one of its functions that of acting as a clearing center for requests and information concerning the two installations.[41]

A group of laboratories which specialized in experiment and research also had the character of field installations. Among them were the Respiratory Diseases Commission Laboratory, the Medical Nutrition Laboratory, the Armored Medical Research Laboratory, and the Army Industrial Hygiene Laboratory, all of which were, for at least part of their careers, closely connected with the Preventive Medicine Division (or Service) of The Surgeon General's Office. In fact, shortly after the war, one element of the Preventive Medicine Service, the Occupational Health Division, was actually transferred to the Industrial Hygiene Laboratory at Edgewood Arsenal, where the Director of the Division became also Commanding Officer of the Laboratory.[42]

Field Installations for Finance and Supply

Like the field installations providing hospital and medical service and those engaged in education and research, the group concerned with finance and supply changed somewhat in numbers, functions, and relation to The Surgeon General's Office during and subsequent to the war. This group included the medical depots, certain other agencies concerned with procurement, and the fiscal branch offices. Medical depots and medical sections of other Army depots antedated the war. At the beginning, procurement was handled by the depots; separate agencies for this purpose made their appearance some nine months after the war started. The first such agencies were the medical procurement districts established on 28 August 1942 in New York and St. Louis. Their successor was the Army Medical Purchasing Office which, beginning in September 1943, concentrated field medical procurement in New York, although certain subsidiary functions were delegated to branch offices in Chicago and St. Louis. In December 1945 the Army Medical Purchasing Office was converted into the Army-Navy Medical Procurement Office, a joint facility of the two services and the first of its kind. The fiscal branch offices of the Medical Department were established at the end of 1942 and the beginning of 1943.[43]

The parts of The Surgeon General's Office having most to do with these finance and supply activities changed from year to year during the war and sometimes almost from month to month. Two trends are noticeable however: a growing specialization of such functions in the Office of The Surgeon General, which increased the number of agencies having jurisdiction over the

field, and at the same time a decentralization of authority from headquarters to the field.

At the beginning of the war there existed a combined Finance and Supply Division (comprising a number of subdivisions) with which the depots had to deal. In 1942 finance was separated from supply and lodged in the Fiscal Division, where it has remained to the present writing.[44] The fiscal branch offices set up shortly afterward were of course very closely connected with this division, especially with its Field Accounting and Audit Supervision Branch (later called the Field Supervision Branch). The function of the branch offices was to "administer all fiscal matters within the depot distribution area," thus decentralizing a system under which some 600 Medical Department installations had reported monthly to The Surgeon General's Office for the funds allotted to them.[45] The status of the fiscal offices was changed on 15 November 1945, owing to "curtailment of procurement and reduction of fiscal activities." Instead of operating as "attached services" at the several depots, the offices became the responsibility of the depots, "subject to technical instructions and audit" by the Fiscal Division, Surgeon General's Office.[46]

About the same time that the fiscal functions of The Surgeon General's Office were being separated from supply and becoming decentralized by the establishment of fiscal branch offices, a similar process was occurring in the realm of supply itself. Before the creation of procurement districts in August 1942, the depots, as we have seen, acted as both procurement and distribution centers. For those purposes they reported to a single branch of the Finance and Supply Division—the Purchase, Storage and Issue Subdivision. When field supply functions were divided between the procurement districts and the depots, a corresponding division took place at Washington with the establishment of separate Purchasing and Distribution Divisions.[47] A Price Analysis and Renegotiation Division came into existence about the same time, but its functions were essentially part of the purchasing or procurement operation. (A chart of The Surgeon General's Office, however, indicates that separate Procurement and Storage & Issue Divisions had existed as early as 26 March 1942. These were superseded in July and August by the entities mentioned above.) It will be convenient to treat the further development of supply organization, so far as the relationships between headquarters and the field are concerned, under the separate headings of (a) procurement and (b) distribution.

(a) In the matter of procurement, the first year of war witnessed a decentralization of functions from headquarters to the field. Added responsibilities delegated to the new procurement districts during this period were:

1. Making of awards and executing contracts for purchases up to and including $1,000,000 (increased from $500,000).

2. Checking contracts for fiscal and legal correctness. (This check was formerly performed in The Surgeon General's Office.)

The Surgeon General's Office however retained important elements of control. Procurements were made only on its specific authorization, and the form of contract used had to receive its approval.[48] Further delegation of functions occurred soon afterward. The Control Division in its report for the fiscal year 1943 stated that "the activities of the Renegotiation Division . . . have recently been largely decentralized into the Procurement Districts where negotiators work with the local procurement officers, making surveys with regard to prices and costs."[49]

When the procurement districts were replaced by the Army Medical Purchasing Office in September 1943, an exodus from Washington toward the new field installations set in. During the next two years a number of offices of the Supply Service moved to New York, including those concerned with procurement. Thus the Procurement Division in Washington was discontinued in November 1943, and although a Purchasing Division remained on the headquarters chart it actually became an integral part of the Army Medical Purchasing Office.[50] The Catalog Branch also joined the Purchasing Office, apparently on the same terms. Other supply offices set up in New York which worked with the Purchasing Office, but never formally combined with it, were the Inventory Control Branch of the Distribution and Requirements Division, the Stock Control Division (successor to the Distribution and Requirements Division), and the Renegotiation Division. Eventually the Purchasing, Renegotiation, and Stock Control Divisions were represented in the Supply Service at Washington only by liaison units.[51]

When the Army Medical Purchasing Office was discontinued and replaced by the Army-Navy Medical Procurement Office on 15 December 1945, the relation of the new agency to higher authority differed somewhat from that of its predecessor. "So far as the War Department aspect of this joint activity is concerned", it remained a Class IV installation of The Surgeon General's Office. But it reported to a two-man Army-Navy Medical Procurement Agency composed of the Chief of the Supply Service (Office of The Surgeon General) and the chief of the Materiel Division (Bureau of Medicine and Surgery, Navy). Through this agency it received technical and administrative supervision from the Office of The Surgeon General and the Bureau of Medicine and Surgery, and direction as to general policy from the Army and Navy Munitions Board. The Army's share of personnel for the office was assigned from The Surgeon General's Office.[52]

The legal side of procurement was at first dealt with by the Legal Division of The Surgeon General's Office under its authority to supervise the legal aspects of contracts. Like certain other phases of the procurement operation, this function was eventually delegated to the field. In October 1943 a Legal Division was created in the Army Medical Purchasing Office at New York to advise on "matters of procurement of supplies, equipment, and services."[53]

(b) As in the case of procurement, the distribution functions of The Surgeon General's Office tended to gravitate toward the field. During the first year of the war the additional responsibilities assigned to the depots were

1. Editing and approval of requisitions originating in the field except for controlled items.

2. Follow-up on delivery of purchased materials.

3. Control of excess property of posts, camps, and stations.

4. Making purchases for depot upkeep and emergency purchases for ports of embarkation.

During the same period however headquarters retained control over

1. Issuance of new Medical Department supply catalog which outlines allowances.

2. Distribution of equipment lists which amplify allowances prescribed in medical supply catalog.

3. Approval of requisitions for controlled items.

4. Issuance of directives to depots establishing policy and procedures and generally supervising operations through reports and field visits.[54]

At the end of the fiscal year 1943 the Control Division, Office of The Surgeon General, reported that the vastness of the distribution problem had caused the decentralization of distribution activities to the depots and stations. The depots, it stated, were now charged with final action on the majority of requisitions and with the disposition of excess medical supplies at stations.[55]

Throughout the war and afterward, the depots remained the only type of medical field installation concerned with distribution.

During the same period, however, several parts of The Surgeon General's Office usually had a special interest in depot operations, and these parts changed frequently with successive reorganizations of headquarters. As we have seen (above, p. 88), the division of supply functions between the depots and procurement districts in 1942 was accompanied (or preceded) by a similar division at headquarters when distribution and procurement were separated and assigned to new agencies. The Distribution Division (later called the Distribution and Requirements Division), which had most to do with the depots, existed from July 1942 to June 1944.[56] It was "responsible for direction and coordination of depot operations; planning for, scheduling, and initiating action to accomplish distribution of medical supplies to depots; and for supplying fixed medical installations and troops in the Zone of the Interior and Theater of Operations."[57] To accomplish these purposes the Division possessed a changing list of branches over the period of its activity. For a time the list included a Depot Branch which controlled "the distribution and storage of stock in the seventeen medical depots."[58] Among the more stable branches was a Stock Control Branch that lasted as long as the Division itself and in a sense survived it. For when a drastic reorganization of the Supply Service occurred in June 1944 the Distribution and Requirements Division was abolished, but a Stock Control Division along with an Issue Division and a Storage and Maintenance Division replaced it.[59] As we have seen, the Stock Control Division ultimately moved to New York, taking its place beside the Army Medical Purchasing Office.

The field installations of The Surgeon General's Office performed important functions during and after the war, and helped increasingly to relieve the burden of administration at Washington. Their status, however, was not uniform in all cases, as the foregoing chapter has indicated, and in certain instances it would be difficult to determine, without a lengthy investigation, precisely what that status was at a given moment. But the uncertainty does not seem to have greatly interfered with the performance of their appointed tasks.

[1]WD Cir. 211, par. 6a(3), 8 Oct 1941.

[2]Ibid, par. 6a(4).

[3]AR 170-10, par. 6(4)a.

[4]AR 170-10, par. 6(4)a.

[5]AR 170-10, 24 Dec 1942, Changes No. 8.

[6]AR 170-10, 24 Dec 1942, Changes No. 7.

[7]SOS Organization Manual, 304.07.

[8]SGO Office Order No. 134, 18 Apr 1946; Office Order No. 39, 5 Feb 1946.

[9]The list of field installations on 28 Aug 1942 includes: Army Medical Library, General Dispensary (Washington, D.C.), Army Medical Center (including Walter Reed General Hospital), Army Medical Museum, New York Procurement District, St. Louis Procurement District (proposed), the medical depots at Binghampton, Savannah, Toledo, St. Louis, Kansas City, Denver, Los Angeles, and San Francisco, and in addition medical sections at the following Quartermaster Depots: Schenectady, New Cumberland, Atlanta, Chicago, San Francisco, Ogden, and Seattle. (1st Ind, Memo for Control Div., SGO, from Control Div., SOS, 28 Aug 1942. Record Room, SGO, 020.-1.)

The list of field installations on 4 Sep 1944 modifies the above by dropping the General Dispensary, the New York and St. Louis Medical Procurement Districts, the Savannah Medical Depot and the New Cumberland, Chicago, and San Antonio medical sections at the Quartermaster depots. The new list adds Carlisle Barracks (including the Medical Department Field Service Schools, the Medical Department Equipment Laboratory, and the Medical Department Board), Old Farms Convalescent Hospital (Special), Army Industrial Hygiene Laboratory, Respiratory Diseases Commission Laboratory, Armored Medical Research Laboratory, Army Medical Purchasing Office (New York) with its Chicago branch, Louisville Medical Depot, the Richmond, Columbus, and Savannah Medical Supply officers in the local ASF Depots, the medical supply officer in the Pueblo Ordnance Depot, and the Veterinary Laboratory in the Quartermaster Remount Depot at Front Roayl, Va. (SGO Office Order No. 183, 4 Sep 1944.)

The List for 18 Apr 1946: Army Medical Center; Brooke Army Medical Center; Percy Jones and Madigan Hospital Centers; 28 General Hospitals; Army Medical Library; Old Farms, Camp Upton, and Welch Convalescent Hospitals; Army Industrial Hygiene

Laboratory; Armored Medical Research Laboratory; Medical Nutrition Laboratory; Army-Navy Medical Procurement Office (New York); SGO activities located at or attached to the Army-Navy Procurement Office for administrative and operating convenience only (Deputy Chief of Supply Service with Renegotiation Division, Contract Adjustment and Property Division, and Stock Control Division; Malaria Control Service of Preventive Medicine Service; Development Division [Liaison] of Army Medical Research and Development Board; Medical Department Regional Fiscal Office of Fiscal Division; Medical Department Equipment Laboratory, Carlisle Barracks, Pa., attached for morning report purposes only; Medical Department Printing Plant, Carlisle Barracks, Pa., attached for morning report purposes only); Denver Medical Depot (including Medical Department 5th Echelon Repair Shop) with its attached Tuberculosis Research Laboratory; and the Louisville, St. Louis and San Francisco Medical Depots. In addition there were medical sections under the technical supervision of, and with medical personnel authorized by, The Surgeon General at the Atlanta, Columbus, Lathrop (Stockton, Calif.), Richmond, Savannah, Seattle, Utah (Ogden), and San Antonio ASF Depots, and at the Pueblo Ordnance Depot. The Veterinary Research Laboratory continued at the Quartermaster Remount Depot (now at Fort Robinson, Nebr), and the Respiratory Diseases Commission Laboratory at Fort Bragg, N.C. (SGO Office Order No. 134, 18 Apr 1946.)

[10]Memo, Director, Control Div., SGO, to Historical Div., SGO, for Annual Report 1943 (Historical Division, SGO).

[11]SOS Organization Manual, 30 Sep 1942, 304.07.

[12]ASF Organization Manual, 15 Aug 1944, 306.00.

[13]Organization Chart, SGO, 24 Aug 1944.

[14]Functional Organization Chart, SGO, War Department, 9 May 1942 (Historical Division, SGO); SOS Organization Manual, 30 Sep 1942, 304.07.

[15]Organization Charts, SGO, 15 Jun, 10 Jul 1943 (Historical Division, SGO).

[16]SOS Organization Manual, 30 Sep 1942, 304.07; ASF Organization Manual, 15 Aug 1944, 306.00.

[17]Functional Organization Chart, SGO, War Department, 9 May 1942 (Historical Division, SGO).

[18]SOS Organization Manual, 30 Sep 1942, 304.07.

[19] ASF Organization Manuals, 1 Oct 1943, 15 Aug 1944.

[20] A Summary of the Training of Army Service Forces Medical Department Personnel, 1 Jul 1939 - 31 Dec 1944. Prepared by Historical Division, Office of The Surgeon General.

[21] Medical Replacement Training Centers also contained Medical Replacement Pools for officers which provided basic training in certain subjects, and Officer Candidate Preparatory Schools to screen aspirants for Medical Administrative Corps Officer Candidate Schools.

[22] A Summary of the Training of Army Service Forces Medical Department Personnel, 1 Jul 1939 - 31 Dec 1944. Prepared by Historical Division, Office of The Surgeon General, sec. I, II, III.

[23] Ibid., pp. 17, 18; SOS Organization Manual, 30 Sep 1942, 304.07/3; ASF Organization Manual, 15 Aug 1944, 306.00/12.

[24] AR 170-10, par. 6a(1)(u), 10 Aug 1942; AR 170-10, par. 6a (1)(u), 24 Dec 1942, and Changes No. 2, 14 Apr 1943, and No. 5, 12 May 1943; ASF Cir, No. 29, 12 May 1943.

[25] Maj. Gen. G.F. Lull to Maj. Gen. C.F. Reynolds, 31 Dec 1945 (Record Room SGO, 323.3 [Carlisle Barracks] N).

[26] WD Cir. 32, 1 Feb 1946.

[27] A Summary of the Training of Army Service Forces Medical Department Personnel, 1 Jul 1939 - 31 Dec 1944. Prepared by Historical Division, Office of The Surgeon General, p. 103.

[28] Annual Report, Headquarters, Army Medical Center 1941; Annual Reports, Medical Department Professional Service Schools, for fiscal years 1942-1945.

[29] A Summary of the Training of Army Service Forces Medical Department Personnel. Prepared by Historical Division, Office of The Surgeon General, p. 11.

[30] Ibid., p. 8.

[31] AR 170-10, par. 6a(1)(u), 10 Aug 1942, 24 Dec 1942 and Changes No. 2, 14 Apr 1943.

[32] Medical Field Service School, Report for Fiscal Year 1943 (Historical Division, SGO); Research Coordination Branch, Report for fiscal year 1943 (Historical Division 319.1-2, Operations Service).

[33]AR 40-405, 29 Jun 1929; AR 40-410, 18 Jan 1922, 6 Jun 1946.

[34]Above, Chapters I and II.

[35]SGO Office Order No. 237, 1 Jul 1942.

[36]Memo for CG, ASF, from Chief, Personnel Service, SGO (Record Room, SGO, 024.-19).

[37]ASF Cir. No. 33, 29 Jan 1944.

[38]Army Medical Library, Report for fiscal year 1944 (Historical Division, SGO).

[39]SGO, Office Order No. 134, 18 Apr 1946.

[40]AR 40-410, par. 1, 7 Jun 1946. Information from the Management Engineering Division, SGO, 26 Jun 1946.

[41]SGO, Office Order 295, 22 Oct 1945; information from Lt. Col. John W. Kemble, Hospital Service, SGO, 26 Jun 1946.

[42]SGO, Office Order No. 253, 25 Sep 1945.

[43]Report on Administrative Developments, SGO, Memo for Control Division, SOS, 1 Dec 1942 from Control Division, SGO (Historical Division, 024.-1); Richard E. Yates, The Procurement and Distribution of Supplies in the Zone of the Interior during World War II, SGO, 31 May 1946, pp. 28, 60-63; ASF Cir. No. 31, 1946; Control Division, SGO, Annual Report, Fiscal Year 1943 (Historical Division, SGO).

[44]See above Chap. III; Organization Charts, SGO, 15 May 1941, 24 Aug 1942.

[45]SGO Cir. Letter No. 177 (Fiscal No. 2) 15 Dec 1942; History of the New York Medical Depot, Binghampton, N.Y., 1 Jan 1943 (Historical Division, SGO).

[46]Director, Fiscal Division, SGO to CO, St. Louis Medical Depot [etc.], 8 Nov 1945 (files of Fiscal Division, SGO).

[47]Report on Administrative Developments, SGO, Memo for Control Division, SOS, from Control Division, SGO, 1 Dec 1942 (Historical Division, SGO).

[48]Ibid.

[49]Control Division, Annual Report, fiscal year 1943 (Historical Division, SGO).

[50]This is the interpretation given by a present spokesman for the Supply Service (Miss A.C. Adam), who witnessed these changes and has participated in office administration since that time. However it is worth noting that the SGO Manual of Organization for 15 March 1944 places a Division Director at the head of the Purchase Division (New York City) and states that he "reports to, advises, and assists The Surgeon General, through the Chief, Supply Service, on matters within the Scope of the Division functions." In other words, the manual gives the Purchase Division the same status as any other division of the Supply Service. This would indicate that the amalgamation between the Purchase Division and the Army Medical Purchasing Office was not so complete as is stated above.

[51]See above Chapter IV; Richard E. Yates, op. cit., pp. 60, 63; information from Miss A.C. Adam, Supply Service, SGO, 13 Jun 1946.

[52]WD Cir 11, Sec II, 11 Jan 1946; memo for Chief of Engineers [etc.] from Chief, Current Procurement Branch, ASF, 22 May 1946 (Record Room, SGO, 323.3 [AMMPO, New York] M); information from Col. S.B. Hays, Supply Service, SGO, 10 Jun 1946.

[53]See above Chapter IV; SOS Organization Manual, 30 Sep 1942, 304.07; ASF Organization Manual, 15 Aug 1944, 306.00.

[54]Report on Administrative Developments, SGO Memo for Control Division, SOS from Control Division, SGO, 1 Dec 1942 (Historical Division, 024.-1).

[55]Control Division, Annual Report for 1943 (Historical Division, SGO).

[56]Yates, op.cit., pp. 58, 60.

[57]Manual of Organization and Standard Practices, SGO, 15 Mar 1944, 3.09 4.

[58]ASF Organization Manual, 30 Sep 1942, 304.07; Organization Chart, SGO, 1 Apr 1943 (Historical Division, SGO).

[59]Yates, op.cit., p. 60.

PART II

THE SERVICE COMMANDS AND GENERAL HOSPITALS

CHAPTER VIII

THE MEDICAL DEPARTMENT IN THE CORPS AREAS AT THE BEGINNING OF WORLD WAR II

The Corps Area Surgeon's Office

At the beginning of World War II, and indeed throughout the conflict, the principal center of organization for Medical Department activities within the corps areas was the corps area surgeon's office, although as we shall see not all such local activities were under his jurisdiction.

In the scheme of command, the corps area surgeon until the middle of 1942 was directly subordinate to the corps area commander, being a member of the latter's "special staff" along with the adjutant general, signal officer, engineer, and others. According to Army Regulations, the surgeon's functions were advisory and administrative—"advisory in his relations as a staff officer, and administrative in his conduct of the Medical Department as a technical service under the control of the corps area commander." His staff duties included those prescribed for all medical officers having such functions; namely, to furnish his commanding officer with information and advice on all questions affecting the Medical Department, including health measures and the care of sick and wounded in the command; to recommend visits of inspection wherever necessary for the purpose of investigating health conditions and the state of Medical Department personnel, equipment, and administration in the command; to submit recommendations to his commanding officer as to the training and utilization of Medical Department personnel; and to supervise all Medical Department activities within the command.[1]

More particularly, the corps area surgeon was responsible for:

1. Reporting to the corps area commander on the efficiency of each medical officer serving in the corps area.

2. Taking action to maintain the quota of Medical Department enlisted men within the corps area.

3. Taking action with regard to transfers, appointments, and reductions of Medical Department enlisted men, and with regard to the rating and disrating of Medical Department enlisted specialists,

4. Recommending the change of station of Medical Department personnel within the corps area.

5. Supervising, under orders of the corps area commander, the instruction and training of Medical Department personnel.

6. Recommending action on estimates for the construction and repair of buildings for the Medical Department.

7. Examining and taking action on requisitions for medical, dental, veterinary, and hospital supplies.

8. Accounting for Medical Department supplies, service, and attendance.

9. Taking action on statements of hospital funds.

10. Approving laundry contracts of stations under corps area jurisdiction.

11. Taking action on leaves of absence and on certificates of disability.

12. Recommending the transfer of patients to general hospitals.

13. Preparing for the action of the corps area commander the program for Medical Department participation in field exercises and maneuvers.

14. Maintaining constant liaison with the corps area commander's staff to obtain prompt information of any contemplated movement or change of policy likely to affect the Medical Department.

15. Preparing certain reports on the health of troops and annual reports on the activities of the Medical Department in the corps area.

16. Keeping himself informed as to the status of enrollment, organization, and training of Medical Department personnel of the National Guard, Organized Reserves, and Reserve Officers Training Corps.

17. Making recommendations to the corps area commander concerning all matters relating to allocation, distribution, and mobilization of Medical Department units of the Regular Army, National Guard, and Organized Reserves serving with or to be mobilized under corps area control, together with the assignment of personnel to such units.

18. Preparing the Medical Department annexes to the corps area general mobilization plan and to supplemental mobilization plans.

19. Recommending all other necessary measures during wartime or national emergency to insure timely and efficient service on the part of the Medical Department within the corps area.[2]

This formidable list of duties not only indicated the broad jurisdiction of the corps area surgeon, but determined to some extent the organization of his office, which will be dealt with further on.

The corps area surgeon was not only responsible to the corps area commander, but received instructions and delegations of authority direct from The Surgeon General. Thus in 1941 The Surgeon General assigned to the Surgeon of the Third Corps Area "the authority to determine proper allocations of positions and the final review of payrolls for station hospitals" in the command.[3] And in the matter of construction and repair of hospitals the corps area surgeons submitted their recommendations to The Surgeon General as to the funds to be allotted for such purposes during each fiscal year.[4] Thus the surgeon and the other members of the corps area commander's special staff were to some extent field representatives of their respective branches of the War Department General Staff. In fact it was asserted later on that this process had gone so far that "the corps area commander had very few functions left. The supply branches in Washington had gradually moved into the picture until the special staff officer on the staff of the corps area commander was commanded and instructed and funds furnished directly from Washington."[5]

Nevertheless after this system had passed, at least one corps area surgeon looked back on it with approval and perhaps a touch of regret:

> Although operations were coordinated with the Chief of Staff or appropriate staff officer he said, the Surgeon enjoyed essentially an autonomy of action. The Surgeon discharged his responsibilities with a minimum of confusion. The delineation of the Surgeon's functions was sharp and well-understood and extended in scope to essentially every installation within the territorial limits of the corps area. Two channels of military correspondence to and from both lower and higher echelons were recognized: command and medical. This system permitted the Surgeon to communicate directly with station and unit surgeons and The Surgeon General on purely medical matters which did not relate to command functions or major changes in policy. This obviated delays in transacting public business, particularly as concerned

> individual evaluations of physical fitness for appointment or active duty and the treatment of patients.[6]

Whether the delineation of the Surgeon's functions was always so "sharp and well-understood" as the above statement asserts may be doubted when one notes a protest from the office of the Ninth Corps Area Surgeon:

> We have been, and continue to be, quite confused by action of The Surgeon General's Office in ordering Ninth Corps Area Reserve Nurses to foreign service by direct contact with station concerned and without reference to this office. We recommend that all changes of personnel, both Regular Army and Reserve Nurses in this corps area be made a matter of information to this office.[7]

This illustrates the fact that not all medical activities within the corps area were within the purview of the surgeon's office. Thus general hospitals with certain exceptions were, until 1942, under the direct command of The Surgeon General.[8] In addition, Medical Department instruction at the Command and General Staff School and the special service schools, veterinary service at quartermaster depots and quartermaster remount stations, veterinary service for animal purchasing and breeding purposes, and the procurement and distribution of medical supplies in general and medical depots—all these medical services were exempt from corps area control and were to be "operated and supplied as directed by the Secretary of War".[9] Moreover, the regulation which placed "all personnel units and installations" on air bases under the authority of the Commanding General, Air Force Combat Command, implicitly removed medical personnel and installations on such bases from the jurisdiction of the corps area.[10] So when the Commanding General of the Sixth Corps Area transferred several Medical Corps officers, on duty at an Air Corps training school, to a port of embarkation—an action which drew a protest from the Air Corps—The Surgeon General acknowledged that the corps area had overstepped its authority.[11]

Apparently, however, the responsibility of the corps area surgeon was not clearly defined with respect to medical matters (such as inspections) which were connected with the Air Corps and Ground Forces but were outside their posts, camps and stations. This difficulty arose in sharper form when the War Department was reorganized in 1942[12] and will be dealt with in that connection.

To discharge their manifold duties the offices of the corps area surgeons were organized on plans that varied

somewhat from one corps area to another but that had basic elements of similarity, as the following examples will show.

Components of Surgeon's Office, 2d Corps Area, as of 31 Dec 1941[13]

Surgeon
Executive Officer
Dental Section
Veterinary Section
Inspection Section

Personnel Section
Professional Service Section
Finance and Supply Section
Statistical Section
Plans and Training Section
Civilian Conservation Corps Section
Liaison with U.S. Public Health Service

Components of Surgeon's Office, 3rd Corps Area, as of 31 Dec 1941[14]

Administrative Section
Finance and Supply Section
Personnel Section
Statistical Section, including sick and wounded and hospitalization
Nursing Section
Dental Section
Veterinary Section
Mail and Distribution Section

A somewhat more elaborate structure is indicated in the diagram of the Surgeon's Office, Eighth Corps Area, as of 31 December 1941 (see Chart XIX). In this plan the functions of the various parts are, in general, sufficiently indicated by their names. In certain cases, however, some further explanation may be needed. The Office Administration Section had charge of "all office activities pertaining to the personnel, both military and civilian, on duty in the Corps Area Surgeon's office, all office supplies and equipment, and the maintenance of the office so that it functions efficiently." The Sanitation Section's duties included "field inspections of the sanitary facilities of the posts, camps, and stations, including Air Corps, located in this corps area." (Obviously, sanitary inspections of Air Corps installations were not considered as infringing the medical autonomy of these posts.) The Construction Section maintained and kept up-to-date the plans and lay-outs of each hospital in the corps area. It also made recommendations on requests for the construction of additional hospital buildings and for the repair or alteration of existing buildings. The liaison official of the U.S. Public Health Service was assigned "to facilitate cooperation between the civilian health authorities and the Army in all matters pertaining to health protection where either the interests of the Army personnel or the civilian population are concerned", including such problems as the disposal of sewage from camps, the exposure of soldiers to health hazards when off the reservation, and the maintenance of safeguards among the civilian population near camps to minimize the transmission of venereal and other diseases to the military.[15]

To operate its various sections the Eighth Corps Area Surgeon's Office employed 37 persons at the end of 1940 and 84 at the end of 1941. Most of this increase was in civilian personnel which rose from 15 to 57; the number of enlisted men (13) remained the same while officers increased from 9 to 14. Meanwhile the strength of the command leaped from 47,164 to 184,985.[16] Somewhat the same changes occurred in the personnel of the other two corps areas mentioned above. In the following table the Eighth Corps Area is included for purposes of comparison.

	1940	1941
Officers:		
Second Corps Area	11	15
Third Corps Area	8 (+ 1 nurse)	14 (+ 2 nurses)
Eighth Corps Area	9	14
Enlisted Men:		
Second Corps Area	9	14
Third Corps Area	3	5
Eighth Corps Area	13	13
Civilians:		
Second Corps Area	16	26
Third Corps Area	9	21
Eighth Corps Area	15	57
Total Personnel:		
Second Corps Area	36	55
Third Corps Area	21	42
Eighth Corps Area	37	84
Mean Strength of Command:		
Second Corps Area	27,807	70,135
Third Corps Area	------	108,143
Eighth Corps Area	47,164	184,985

General Hospitals

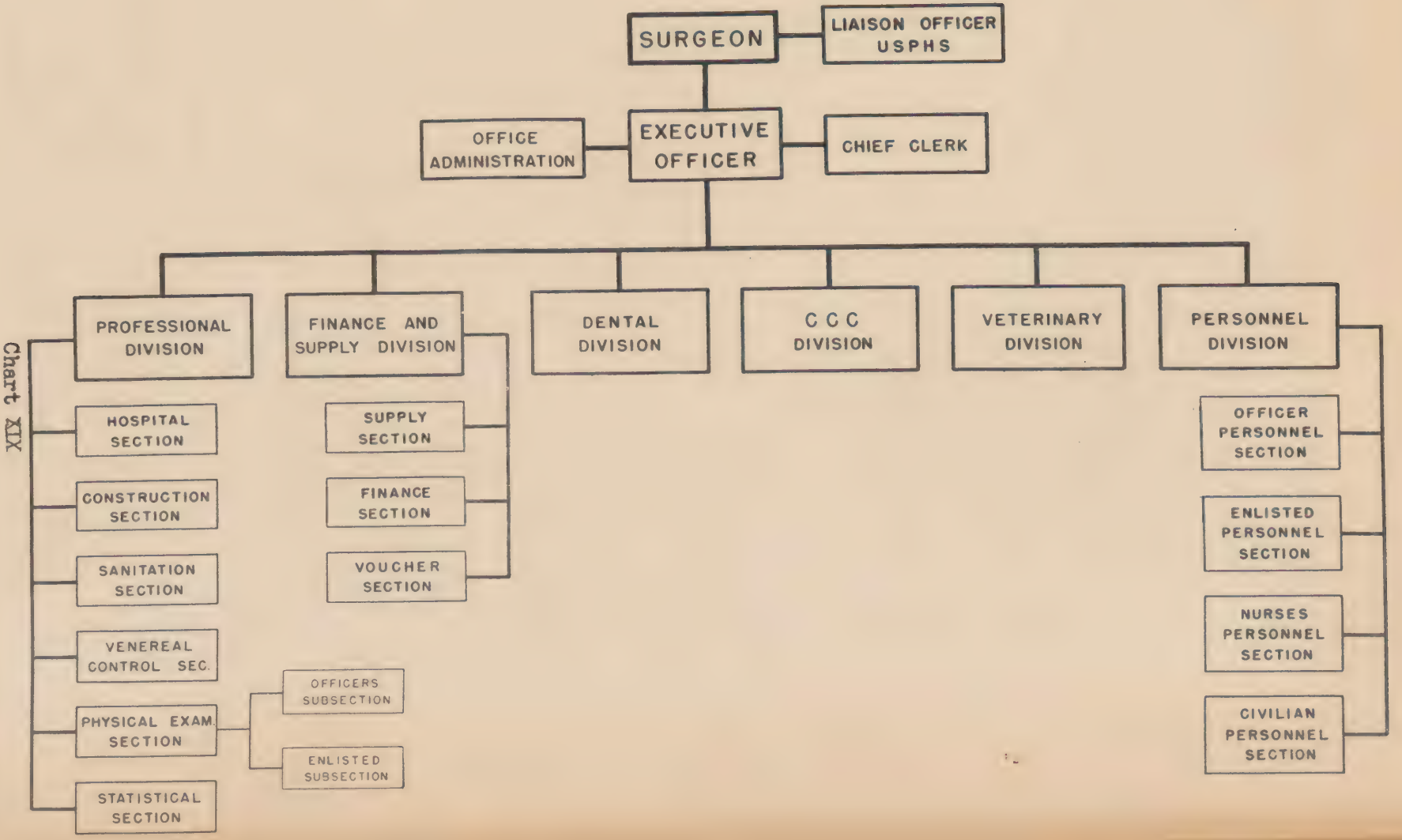
Besides the corps area surgeon's offices, the general hospitals were important local centers of Medical Department administration. These hospitals, although located within the geographical boundaries of corps areas, were not subject to corps area control until 1942, unless specific authority over them was delegated by The Surgeon General to

ORGANIZATION CHART

SURGEON'S OFFICE, EIGHTH CORPS AREA

31 DECEMBER 1941

Chart XIX



the corps area commander. As this statement implies, the general hospitals were directly subordinate to The Surgeon General, except in the case of Walter Reed Hospital whose commanding officer was immediately responsible to the commanding officer of the Army Medical Center.[17]

The internal organization of general hospitals was governed in broad outlines by Army Regulations. The senior medical officer of the hospital was to command it.[18] In other respects the rules did not differ from those formulated for all Army hospitals. They prescribed a certain nomenclature to designate the more important administrative and clinical personnel. But the structure of hospital organization and the sub-division of authority were not rigidly set down; the commanding officer was merely to "organize the professional and other activities of his hospital into services after the manner of well-organized hospitals in civil communities." The services "customarily established in large hospitals" were listed alphabetically, but "considerable variation therefrom will be left to the discretion of the commanding officer . . . , who may create additional services under appropriate titles . . . when a necessity therefor exists." The services listed were administrative; dental; eye, ear, nose, and throat; laboratory; medical; neuropsychiatric; nursing; orthopedic; physical reconstruction; roentgenological; surgical; and urological. The administrative service "will include such personnel and activities as the commanding officer of the hospital may prescribe"; the following personnel "properly belong in the administrative service": commanding officer, adjutant, personnel officer, registrar (including commander of detachment of patients), officer of the day, chaplain, and chief nurse.[19]

Much more specific on matters of organization was a War Department manual dealing with general and station hospitals, prepared under the direction of The Surgeon General.[20] This described the organization of a general hospital in some detail and was particularly full on administrative procedure. The organization, it said, fell "naturally" into three divisions: The headquarters, consisting of the commanding officer and his staff; the administrative service; and the professional services. The professional services, however, were "not an organic element of the unit"; the chief of each was on an equal footing with all the rest in direct subordination to the commanding officer. The structure of a general hospital therefore was arranged in the following manner:

Headquarters

Commanding Officer

Staff

Executive Officer
Adjutant
Medical supply officer
Chaplain
Personnel officer

Administrative Service

Registrar
Director of Dietetics
CO, Detachment of Patients
CO, Medical Detachment
Receiving and Disposition Officer
Principal Chief Nurse
Hospital Inspector
Officer in Charge of Utilities

Professional Services

Medical Service:
- Gastroenterology
- Neuropsychiatric
- General Medicine
- Cardiovascular
- Communicable Disease Officers

Surgical Service:
- Orthopedic
- Urologic
- Eye, Ear, Nose, and Throat
- General Surgery

Laboratory Service

Roentgenological Service

Dental Service

Dispensary and Out-Patient Service:
- Pharmacy
- Prophylaxis
- General Examinations and Treatments.

The five main professional services, it was pointed out, might be "divided into sections as desired by the chief of service and approved by the commanding officer." An accompanying chart sketching the organization of a hospital was to be "used as a guide only."[21]

On the basis of the above view of army regulations and the manual pertaining to hospitals, we may examine the organization of three general hospitals to see how far they conformed to what may be called the "standard" type, and how far the commanders used their discretionary power in departing from it. For this purpose, Lawson General Hospital (Atlanta), Lagarde (New Orleans) and Stark (Charleston, S.C.) have been chosen because the information regarding their organization in 1941

is more complete than that of other and better known general hospitals.

All three follow this standard plan in possessing administrative and professional divisions. Lagarde and Stark departed from it, however, in having no separate headquarters or staff division; in both cases this was merged in the administrative division. The latter contained most of the offices assigned to the headquarters and administrative divisions in the standard plan: executive officer, adjutant, principal chief nurse, medical supply officer (only a quartermaster is listed at Lawson), registrar, and utilities officer. The chaplain, personnel officer, director of dietetics, commanding officers of the medical detachment and detachment of patients, the receiving and disposition officer, and the hospital inspector (or their equivalents) are missing from the Lawson list, and the two detachment commanders from that of Lagarde. Very probably in some cases these functions were combined with those of named officers. On the other hand, all three hospitals contained administrators not mentioned on the standard list, such as the post exchange officer, the provost marshal (Largarde and Stark), the training officer (Lawson and Stark), and the summary court (Lawson). Stark was particularly rich in this variety of functionary, having a total of twenty-nine all told, including, besides those already mentioned, a prison officer, a librarian, a fire marshal, an ordnance officer, a signal officer, an intelligence and public relations officer, an officer in charge of hospital police and personnel, a billeting officer, an officer in charge of outside police, and a station surgeon. All twenty-nine, it was stated "are responsible directly to the Commanding Officer for the proper conduct and administration of their respective departments." In some cases of course, several of these responsibilities were undoubtedly lodged in the same person.[22]

The organization of the professional services followed the standard model more closely. The six regular sections of the medical service appeared at all three hospitals, except that Lagarde lacked a cardiovascular section, while at Lawson neuropsychiatry was established as a separate service with four sections of its own: psychiatry, neurology, occupational therapy, and the detention ward. In addition Lawson and Stark possessed a section for dermatology and syphilology; Stark also had a section for allergic and metabolic diseases, and one for arthritis and rheumatic diseases.

The arrangement of the surgical service at these three hospitals likewise resembled the official pattern. Instead of one general surgery section, however, there were general and septic surgery sections at Stark, and "clean" and septic surgery sections at Lagarde. The latter also had a section devoted to maxillo-facial surgery, while Stark and Lawson had

sections for "anesthesia and operating" and for physiotherapy. At Stark roentgenology was only a section of the surgical service; at Lagarde and Lawson it was established as a separate service in accordance with the hospital manual. Only Lawson maintained an officers' and women's section in the surgical service.

Separate laboratory and dental services existed at all three hospitals in conformity with the model. At Stark, the dental service contained three sections: oral surgery, prosthetic dentistry, and operative dentistry. The usual outpatient service appeared at Lawson and Lagarde but is not listed at Stark. Other variations from the standard type were a separate "nursing service" at Lawson and a Red Cross agency at Stark which included a field director and three sections: social service, recreation, and stenographic.

In general it will be noticed that the number of individuals and services reporting directly to the commanding officer was apparently largest at Stark on account of its long list of administrative officers, although Lawson had the most professional services—nine as compared to six for Lagarde and four for Stark. While neither Army regulations nor the manual for hospitals specifically limited the number of persons or agencies so reporting, the matter became a subject of discussion later on, and attempts were made to reduce what was regarded as an excessive centralization of authority in the hands of the commanding officers of general hospitals. This was but one phase of Medical Department reorganization which will be dealt with in the following chapters.

NOTES FOR CHAPTER VIII

[1]AR 170-10, 4, 10 October 1939; AR 40-5, 4b, 15 January 1926; 40-10, 2b, 17 November 1926.

[2]AR 40-5, 5, 6, 15 January 1926.

[3]Annual Report, Third Corps Area, 1941.

[4]AR 40-585, 3a, 16 July 1931.

[5]Committee for Study of the Office of The Surgeon General of the Army, 1942, p. 169 (hereafter referred to as Wadhams Committee).

[6]History, Office of the Second Corps Area and Second Service Command, 9 September 1940 - 2 September 1945 (Historical Division, SGO).

[7]Office of the Ninth Corps Area Surgeon, 27 September 1941. (Record Room, SGO, 323.3-2, Ninth S.C.).

[8]AR 40-600, 2, 31 December 1934.

[9]WD Circular Number 211, 6a(3), 8 October 1941.

[10]AR 95-5, 4h, 20 June 1941.

[11]Office of Chief of Air Corps to AG (thru SG), 15 January 1942 (Record Room, SGO, 323.3-2 [6th CA] AA).

[12]Report of The Surgeon General's conference with corps area and Army surgeons, 25-28 May 1942 (Record Room, SGO, 337.-1).

[13]Annual Report, Second Corps Area, 1941 (Historical Division, SGO, 319.1-2 [2d CA] AA).

[14]Annual Report, Third Corps Area, 1941 (Historical Division, SGO, 319.1-2 [3d CA] AA).

[15]Annual Report, Eighth Corps Area, 1941 (Historical Division, SGO, 319.1-2 [8th CA] AA).

[16]Annual Reports, Second and Third Corps Areas, 1941 (Historical Division, SGO, 319.1-2 [2d and 3d CA] AA).

[17]AR 40-600, 2, 31 December 1934; MR 4-3, 4, 2 April 1934. vesting administration of general hospitals in corps area commanders beginning on "M-day", was revoked so far as this provision is concerned by MR 4-2, 3, 13 February 1940.

[18]AR 40-600, 2, 31 December 1934.

[19]AR 40-590, 3a, b, 4a, 21 November 1935.

[20]Technical Manual 8-260, Fixed Hospitals of the Medical Department (general and station hospitals), 16 July 1941.

[21]Ibid., ch. 1, sec. I; p. 74.

[22]Annual Reports of Lawson, Lagarde and Stark General Hospitals, 1941 (Historical Division, SGO).

CHAPTER IX

THE REORGANIZATION OF 1942

The Medical Department in the corps areas underwent a number of changes in structure and functions during 1942. The most important of these followed, and probably to a very great extent resulted from, larger changes throughout the whole War Department, including The Surgeon General's Office. In order to understand what happened to the local medical authorities, therefore, it is desirable to start at the center and work toward the extremities.

The New Chain of Command

Early in 1942 the various arms and services of the War Department were consolidated into three groups: Army Ground Forces, Army Air Forces, and Services of Supply. In this new ordering the Office of The Surgeon General, which had formerly been directly responsible to the War Department Chief of Staff, was now subordinated to the Commanding General of the Services of Supply.[1] Following this, the Services of Supply initiated a reorganization of the corps areas. The project was discussed with the chiefs of the supply arms and services in Washington and explained at a conference of the corps area commanders at Chicago on 30 July 1942.[2] The reasons for this reorganization, as stated in directives issued by the Services of Supply, were to fit the corps areas (or service commands as they were now called) for war-time needs and to adjust them to the new alignments of the War Department. "The previous service command structure," it was pointed out, "was tactical in character because, until recently, the mission of the service command was partly tactical. This is no longer true. Tactical responsibilities are now assigned to Ground Force, Air Force, and Defense Commands." Thus, "the plan of service command organization . . . was not geared to the most efficient accomplishment of these basic functions of the Services of Supply"—that is, the proper classification and assignment of recruits, the quick and complete supply of troops in training, the complete equipment and rapid transport of troops for overseas duty, the relief of field commanders from responsibility for administrative detail, and the efficient handling of security and intelligence.[3]

According to a representative of Headquarters, Services of Supply, a study of the situation "disclosed that there was a definite possibility of using the corps area set-up as a miniature SOS in the field."

> If the commanding general, SOS, could delegate the responsibility and authority as far as possible down to the service commands, they in turn delegating down to post commanders, we could get prompt action and handle this job without any delay incident to papers and action being taken in Washington. So it was decided that, with the exception of procurement, new construction, and certain training activities, the service commander would be responsible as a field agent of the Commanding General, SOS, and as the agent of the supply services here in Washington.[4]

The new structure and functions of the service commands were set forth in a Services of Supply organization manual dated 10 August 1942. (It should be stated that an almost identical manual preceded this under date of 22 July 1942, but the August pamphlet is the one usually cited.). The manual was "an amplification of AR 170-10, as revised 22 July 1942."[5] It announced that efforts would be made "to modify details of outstanding circulars, bulletins, and regulations to conform to this simple plan of operations. However, action must not be delayed while waiting for these procedural adjustments."[6]

According to the new manual the service commander was the field representative of the Commanding General, Services of Supply, and now had complete jurisdiction over the offices of his former special staff (including that of the service command surgeon). The latter were not to be considered field offices or agencies of the supply and administrative services in Washington, or under their direct command and jurisdiction. These services (including The Surgeon General's Office) acted as staff agencies of the Commanding General, Services of Supply, for the functions assigned to them. They had the authority to supervise these functions in the service commands, and for that purpose could issue instructions in the name of the Commanding General, Services of Supply, to the service commanders. "The Commanding General, Services of Supply," as one of his staff put it, "is the boss. But he has, say, The Surgeon General as one of his staff officers. Well, that Surgeon General has the authority to sign the boss's name to those papers, or by authority of the boss." Where formerly the chiefs of the services in Washington had delegated authority to the members of the service commander's special staff, the Commanding General, Services of Supply, now delegated it to the service commander.[7]

Thus the position of the corps area surgeon (now renamed chief of the medical branch) had changed with respect to The

Surgeon General, in that the latter's direct authority over the surgeon had been abolished, leaving him entirely within the jurisdiction of the service commander. This change resulted from an intention "to place complete responsibility and commensurate authority for the field operations of the Services of Supply, except procurement, depot storage, new construction, post operation and certain other transportation operations, clearly in the hands of service commanders." The latter were "given and expected to utilize maximum initiative in the organization of details."[8]

The new system introduced a further change in the relations between the surgeon and the service commander. Not only was the surgeon completely subordinated to the service commander, but his subordination became indirect instead of direct. He was, so to speak, moved down a peg. This resulted from a plan to eliminate "the previous confusion arising from a large number of independent groups reporting to the service commander"—a plan whereby the number of persons in service command headquarters so reporting was reduced from "an average of thirty or more" to eleven. This was accomplished by consolidating all activities into seven "well-defined homogeneous groupings of functions": administration; personnel; supply; real estate, repairs and utilities; operations and training; internal security; and intelligence.[9] It will be noticed that in this organizational structure medical activities do not constitute one of the primary groups. They were, in fact, considered to be merely one function of the supply division. The surgeon, therefore, was subordinated to the head of that division. He became chief of its medical branch on the same footing as the chiefs of seven other supply branches: army exchange, chemical warfare, engineer, ordnance, quartermaster, transportation, and signal corps.[10]

The new organization of the service commands was intended to reflect that of higher headquarters. A Services of Supply memorandum of 22 July 1942 pointed out that "the former corps area special staff offices are combined with new functional staff divisions . . . similar to the staff divisions of the Headquarters of the Services of Supply." Moreover, a revised manual issued in December 1942 stated that in making certain permissible readjustments of the plan, service commanders should "bear in mind the desirability of making the organization of their headquarters parallel, as far as possible, the organization of the Services of Supply in Washington."[11] But it should be noted that, whereas The Surgeon General reported directly to the Commanding General, Services of Supply, the chief of the medical branch (and the chiefs of other supply branches as well) reported to the service commanders only through an intermediary, the director of the supply division. If it is said that the director of the supply division was

analogous to the head of the Services of Supply, the comparison is inexact. The real analogy was between the latter and the service commander, whose overall mission was that of supply and who, moreover, was the field representative of the commanding general of that service.

In this connection it may be observed that when outlining the structure of post commands the organization manual places the post surgeon on the same level with supply and other services, in direct subordination to the post commander (see Chart XX).

In the reorganization of their headquarters, service commanders were permitted to elaborate on, if not to diverge from, the plan outlined in the manual. "The normal subdivision of the functions of the headquarters staff divisions," it was stated, "are shown on the organization chart" (see Chart XX). "Further subdivisions will be made according to the problems peculiar to each service command."[12] Apparently this statement needed some clarification, and the revised version of December 1942 announced that

> the organization of the headquarters staff divisions will be as shown on the chart . . .[13] Functions alloted to a particular division . . . will not be transferred to other divisions without the approval of the Commanding General, Services of Supply. However the subdivision of functions into the branches shown . . . is not mandatory, . . . Major deviations from the organization shown should be reported to the Commanding General, Services of Supply, for the information of Headquarters, Services of Supply.[14]

This would apparently permit the creation of new branches within a division but not the transfer of a branch—such as the medical branch—from one division to another without permission from higher headquarters.

Such a transfer had already taken place in the case of the medical branch. In September 1942, only a month or so after the new plan took effect, Headquarters, Army Service Forces (formerly Services of Supply), informed The Surgeon General that "the Commanding General of the Sixth Service Command has transferred all staff medical functions, except medical supply, from the Supply Division to the Personnel Division. This is a logical arrangement and undoubtedly will also be effected in other service command headquarters."[15] The new arrangement was apparently unsatisfactory, however, for the revised organization manual of December 1942 kept (or replaced) the medical branch in its former division, now

SERVICE COMMAND ORGANIZATION CHART

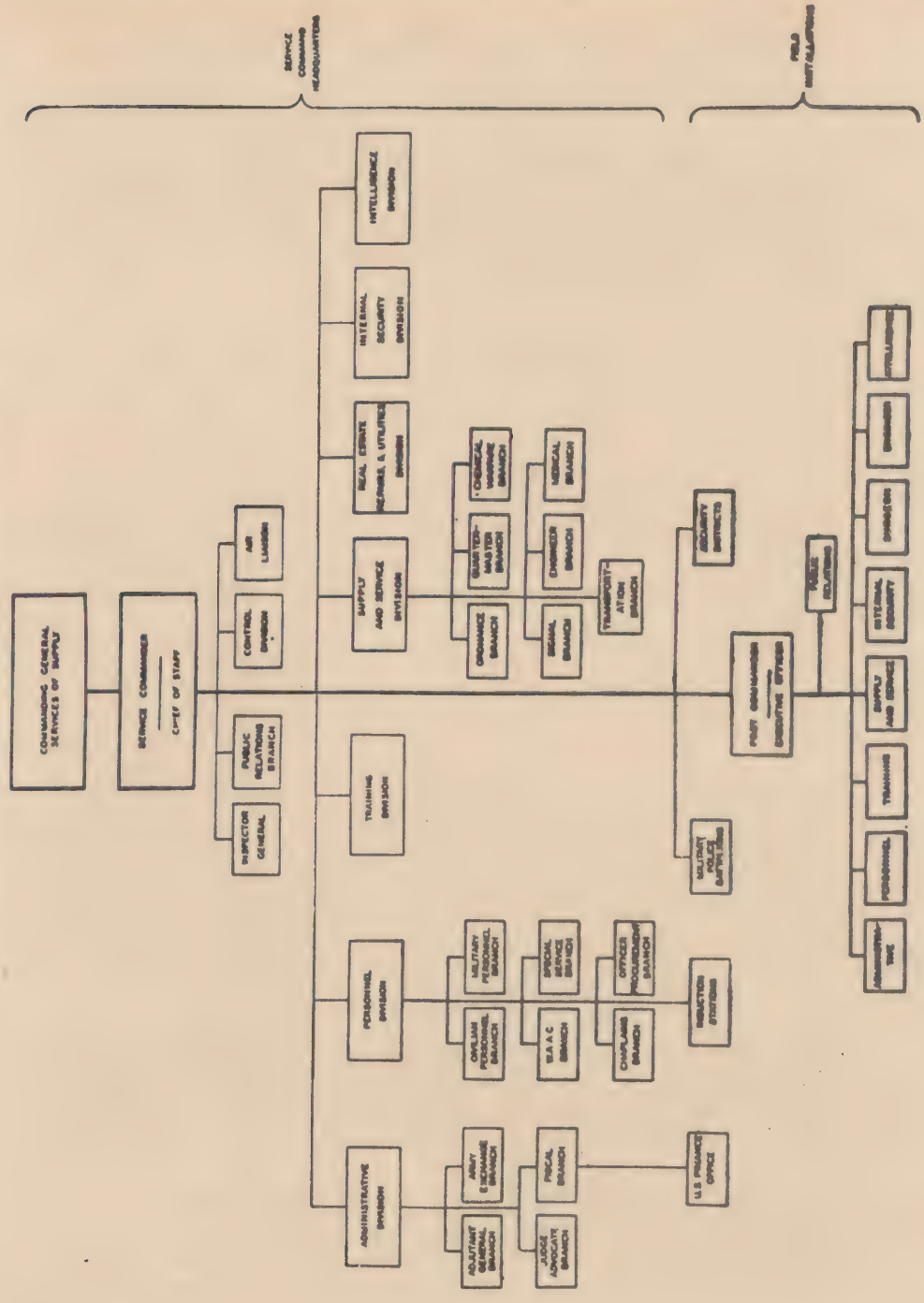


Chart XX

renamed the Supply and Service Division.[16]

Functions of the Service Command Medical Branch

The organization manual did not prescribe the internal organization of the medical branch, or in fact that of any other branch within the service command headquarters. Nevertheless the redistribution of functions which the manual announced encouraged structural changes within the branches. Before considering the internal arrangements of the medical branch as they existed after the reorganization of the service commands, therefore, it will be useful to describe the functions of the branch under the new system. The period dealt with extends to the end of 1942, covering certain revisions introduced by the new manual issued at that time.

The general functions of each headquarters division of the service command were of three types: (1) planning, policy-making, and staff supervision of its particular functions throughout the service command; (2) the actual execution of certain operations within the service command headquarters; and (3) the execution of specific operations in the field.[17] Since the medical branch was a segment of one of these divisions, the assumption is that it was to participate in such functions so far as medical activities were concerned.

The particular duties of the corps area surgeon were enumerated in an Army Regulation issued in 1926 (as described in the preceding chapter). Since this regulation had not been rescinded, the description of the medical branch's functions given in the organization manual must be considered as a summary restatement of these duties to meet new conditions. The first issue of the manual, without referring directly to the surgeon or even the medical branch, states that the supply division, "in performance of its hospitalization, evacuation, and sanitation function performs the following staff functions for the service commander:"

> (1) Supervises service command hospitalization and medical services, outpatient service, evacuation activities, preventive medicine service, industrial accident service, gives advice on occupational hazards and diseases for all military and civilian personnel within the jurisdiction of the service commander and for civilian employees of Government-operated industrial plants as directed, and issues instructions and gives advice regarding

prevention of spread of communicable diseases.

(2) Supervises inspection service at market centers, plants, and depots in connection with procurement of meat and food supplies.

(3) Supervises the operation of all medical examining boards and medical examinations; interprets physical standards and makes final decisions on the physical qualifications and requests for waivers of physical defects of Reserve officers ordered to active duty and of applicants for the Army, the Army Specialist Corps and the Women's Army Auxiliary Corps in accordance with established War Department policies.

(4) Supervises the charting of vital statistics.

(5) Maintains contact through post surgeons with United States Public Health officers who keep posts informed of health conditions in civilian communities adjacent to posts.[18]

This description says nothing of the supply, training, or personnel responsibilities of the medical branch. It could be assumed that the latter would continue to have a hand in these matters, but precisely how and to what extent was not stated or even implied. Personnel matters were assigned to the personnel division, training functions to the operations and training division, and supply responsibilities to the supply division, without mentioning the degree to which the medical branch might be involved. In practice the medical branch, at least in some service commands, continued to share these responsibilities. With regard to training, the surgeon of the Second Service Command stated that "this office has supervised training of Medical Department personnel to a varying degree at all . . . posts, camps, and stations. . ."[19]

The revised manual of 24 December 1942 did something to clear up these points. The training division was to obtain "recommendations of technical branches of other divisions on technical matters related to training." This, of course, included the medical branch. Further, the medical branch was to recommend "policies regarding assignment and transfer of Medical Corps specialists and technical personnel within the service command." Finally

it was to exercise the supply functions allotted to all branches of the supply division individually. These included (1) staff functions relating to its particular supply service, such as supervision of all service command activities in local procurement, distribution, issue, storage, inspection, maintenance, repair, replacement and reclamation of supplies and equipment; (2) stocking and issuing such supplies and equipment for service command headquarters, and (3) reviewing contracts and purchase orders pertaining to service command activities where such review action by the service commander was required. The new manual also specifically mentioned the medical branch and its chief, and named him "personal advisor to the service commander on all matters concerning the health of the personnel of the service command. In the performance of this function the chief of the medical branch is responsible directly to the service commander."[20] This, it was pointed out, permitted some autonomy on the part of the branch chief; he did not have to channel such advice through the director of the supply and service division, who was not a physician.[21]

The status of the medical branch with regard to training was still not perfectly clear, but the Second Service Command interpreted the new manual to mean that supervision of medical training would be a responsibility of the medical branch, while policy would be promulgated by the training division.[22]

The changes in, and restatements of, function just described primarily concerned the new position of the medical branch with respect to other elements of service command headquarters. These changes, however, were accompanied by others which were mainly connected with the scope of service command jurisdiction. As this jurisdiction narrowed or expanded, the functions of the medical branch often contracted or expanded with it. Thus the August 1942 list of installations under authority of the service commander (and therefore under his medical branch) included certain ones not previously so assigned. Perhaps the most important of these were the named general hospitals (other than Walter Reed Hospital) which had formerly been controlled directly by the Office of The Surgeon General. However, the allocation of beds in the hospitals and the determination of their staffs were retained by the Commanding General, Services of Supply.[23]

Certain installations continued to be exempt from service command authority. Among those listed in August 1942 were defense command installations, the Military District of Washington, and the Military Academy.

There were some doubtful cases. "The original definition of responsibilities," says the Second Service Command history,

> were [sic] not sufficiently exact, particularly as concerned medical service at ports of embarkation and staging areas. It was assumed, initially, that the medical service of the Army Transport Service was intended to be exempt, but that medical activities at staging areas would be under the Service Command; however, subsequent publications did not confirm this interpretation and the post surgeon was required eventually to duplicate nearly all of the Service Command Surgeon's staff except the professional consultants subsequently assigned to the Service Command whose numerical inadequacy did not permit such duplication.[24]

The same uncertainty prevailed before and even after the organization manual appeared in August 1942, as to the responsibilities of the surgeon's office concerning Air Force installations.[25] To clarify this matter, a letter from Headquarters, Services of Supply, to all corps area commanders (26 May 1942) had informed them that routine conduct of Medical Department activities at Air Force installations would be the responsibility of the surgeon at such installations acting under the Air Surgeon. But the air station surgeons were to submit basic reports required by The Surgeon General and also estimates of Medical Department funds to the corps area surgeon for transmission to The Surgeon General. Further, "you [the corps area commander] will act as direct representative of The Surgeon General directing such technical inspections as you deem necessary to determine the efficiency of Medical Department activities."[26] Some months later, however, the Chief of Professional Services, Office of The Surgeon General, asserted that "despite the seeming clarity of these provisions" they were rescinded by the organization manual of 10 August 1942, except so far as they applied to hospitals under command of the service command. (This was not strictly accurate. The organization manual made sanitation at Air Force installations a responsibility of the service command, citing the letter of 26 May 1942 referred to above.) As a result The Surgeon General had to attempt to supervise air station hospitals through the Commanding General, Army Air Forces, and the several Air Force commands. In the opinion of the Chief of Professional Services, "unless a policy can be established for technical supervision of medical service on a simple geographical rather than a complicated interwoven and overlapping command basis, the standard of professional care will not measure up to that

which could be otherwise attained."[27] The question continued to be debated for a long time afterward.

The service command surgeons lost one function in 1942 about which there could be no argument. Their authority to supervise medical activities in camps of the Civilian Conservation Corps disappeared when the CCC was terminated in that year.[28]

Internal Organization of the Medical Branch

The changes and restatements of functions just discussed, together with the organizational changes at higher levels previously mentioned, helped to produce certain modifications in the structure of the medical branches throughout the various service commands. Precisely what form these modifications would take depended on how the functional changes were interpreted locally and on how the individual service commanders and branch chiefs decided to implement them. The same may be said of other administrative changes as they applied to the service commands; for example, the appointment of medical consultants required their absorption into the structure of the medical branch, but how that was to be done was a problem for the local authorities.

The setting up of a personnel division as one of the primary elements of the service commander's office was followed by various readjustments in the medical branch. Thus, in the First Service Command the procurement of officers and nurses was removed from the surgeon's office and placed in the personnel division. In the Eighth Service Command the whole medical personnel subdivision was transferred from the surgeon's office to the new personnel division; later the officer assignment section was restored to the medical branch. In the Third Service Command, the civilian personnel section of the surgeon's office moved into the personnel division.[29]

Other changes occurred in the realms of supply and training. When the surgeon's office became a branch of the supply division, the finance and supply division of the surgeon's office (Eighth Service Command) was renamed the supply and voucher section (the chart for 1 January 1943, however, shows only an administrative section). Several of its subsections had already been discontinued or transferred earlier in 1942 by War Department orders.

Temporary removal of the medical branch from the supply division to the personnel division caused other shifts. In the First Service Command the supply section of the medical branch was taken away from it and then restored when the medical branch returned to the supply division. Medical Department training matters in the First Service Command became a

function of the operations and training division, but they were handled by a medical officer selected by, and working in collaboration with, the surgeon. The Eighth Service Command had its own training subsection, a segment of its plans and training section.[30]

During 1942 and early 1943 certain functions were assigned to the medical branch which affected its structure, although they had nothing to do with the general reorganization of the service commands. One of these new responsibilities was the supervision of medical activities in Army owned or operated industrial plants.[31] To provide for this, the medical branch of the Eighth Service Command established an industrial medicine section; the parallel agency in the Third Service Command was an industrial medicine subsection of the preventive section. The appointment of medical consultants by The Surgeon General to operate in four of the larger service commands brought about the creation of a consultants section or subsection in the medical branches of the Eighth and Second Service Commands.[32]

In the First Service Command, there was discussion as to whether the veterinary service should be separated from the surgeon's office as a result of the service command reorganization. It was finally decided that veterinary responsibility for sanitation, disease prevention, and the inspection of dairies, packing houses, and meat products made the service part of the medical branch.[33]

The following table, with similar sections placed opposite each other for purposes of comparison, shows the alignment of the medical branches in two service commands shortly after the reorganization of 1942.[34]

Third Service Command	Eighth Service Command
Administrative Section:	Administrative Section
Receiving and Distributing Mail	
Filing	
Personnel	
War Plans	
Miscellaneous	
Professional Service Section:	
Distribution and Qualification of Medical Officers	
Standards for Medical Care	
Physical Standards	Physical Classification Section
Medical Examining Boards	
Training	Training Section

Third Service Command	Eighth Service Command
Preventive Section:	
Industrial Medicine	Industrial Medicine Section
Sanitary Engineering	Sanitation Section
V.D. Control	Venereal Control Section
Communicable Diseases	
Vital Statistics	
Supply and Finance Section:	Supply Section
Procuring and Requisitioning of Medical Supplies	
Review and Preparation of Vouchers for Civilian Medical and Dental Attendance	
Procuring and Vouchering Accounts for Spectacles	
Coordination of Medical Supplies for Tactical Units	
Coordination of Medical Department Construction Projects	
Nursing Section:	Nurses Section
Recruiting and Appointment and Assignment of Army Nurses	
Distribution and Qualifications of Army Nurses	
Inspection of Nurses Service at Stations	
Dental Section:	Dental Section
Distribution and Qualification of Dental Officers	
Standard Dental Care and Treatment	
Inspection of Dental Service at Stations	
Veterinary Section:	Veterinary Section
Distribution and Qualifications of Veterinary Officers	
Coordination of Inspection of Food products of Animal Origin	
Sanitary Inspection of Establishments, etc., Milk Plants and Dairies - Appeal Inspection	
Care and Treatment of Public Animals	
	Consultants Section
	Hospitalization and Statistics Section
	Food and Nutrition Section

Comparing this arrangement of the medical branch, Third Service Command, with that of 1941 (above p. 101) it will be noticed that the main changes are the absence in 1942 of the hospitalization and statistics division and the personnel division. Certain personnel matters, however, continued to be dealt with in the nursing, dental, veterinary, and professional service sections. The medical branch of the Eighth Service Command during the same period also dropped its personnel division, but added food and nutrition, industrial medicine, plans and training, and consultants section (cf. Chart XIX).

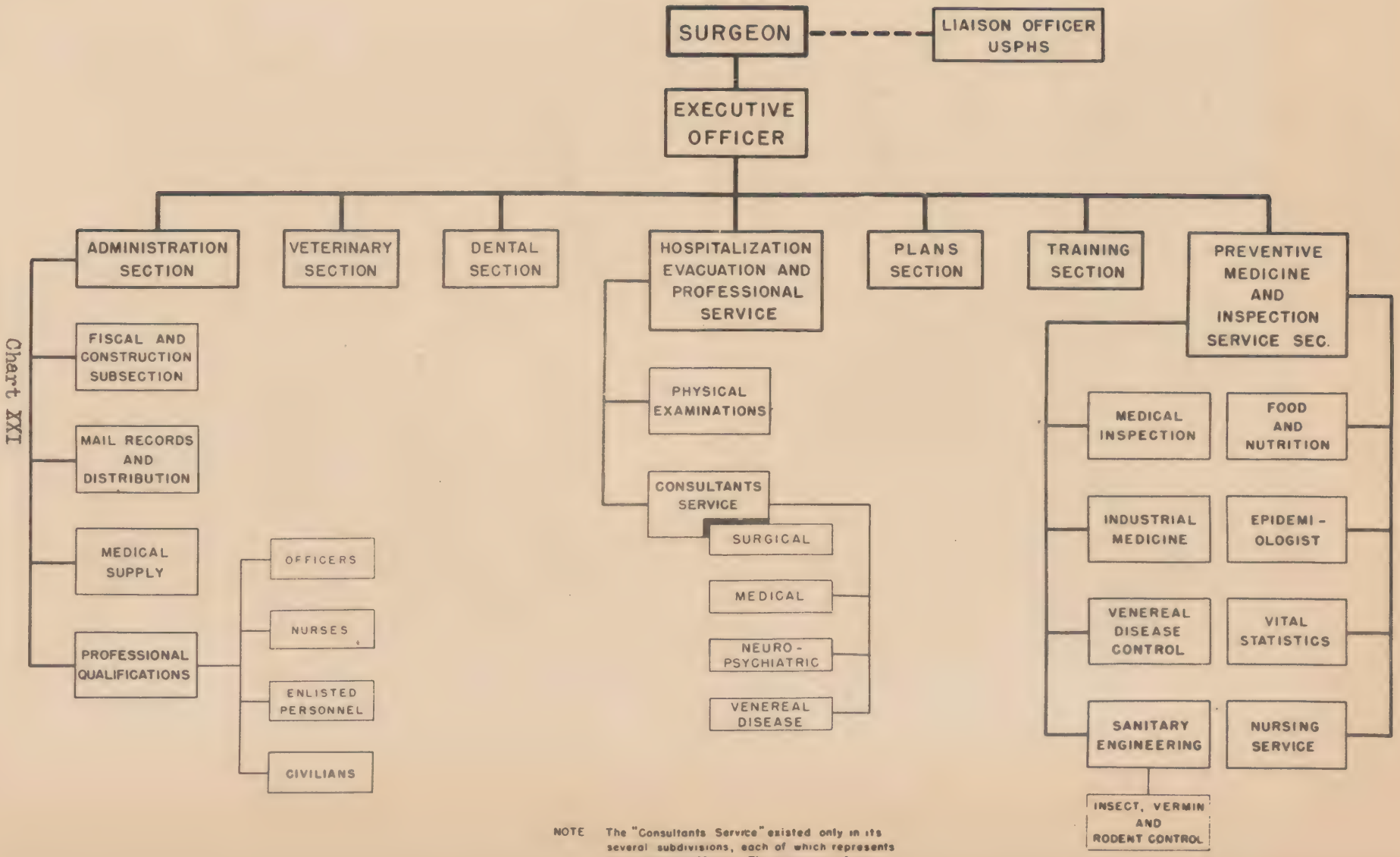
A detailed organization chart of the medical branch, Second Service Command, is available for 1942[35] (see Chart XXI). A comparison with the 1941 table (above p. 101) shows that the most notable omissions were the personnel section and the civilian conservation corps section, although some personnel matters were now handled in the professional qualifications subsection.

The number of personnel employed in the medical branches of the Second, Third and Eighth Service Commands before and after reorganization, together with the mean strength of the commands, are shown in the following table.[36]

	1941	1942
Officers:		
Second Corps Area	15	16 (+2 nurses)
Third Corps Area	14 (+3 nurses)	15
Eighth Corps Area	14	29
Enlisted Men:		
Second Corps Area	14	16
Third Corps Area	5	1
Eighth Corps Area	13	3
Civilians:		
Second Corps Area	26	28
Third Corps Area	21	28
Eighth Corps Area	57	60
Total Personnel:		
Second Corps Area	55	64
Third Corps Area	42	44
Eighth Corps Area	84	92

ORGANIZATION CHART
MEDICAL BRANCH
SECOND SERVICE COMMAND
15 MARCH 1943

Chart XXI



NOTE The "Consultants Service" existed only in its several subdivisions, each of which represents one medical officer. The services of two civilian employees are pooled.

Mean Strength of Command:	1941	1942
Second Corps Area	70,135	160,000
Third Corps Area	108,143	165,648
Eighth Corps Area	184,985	490,055

The small increase in personnel (4 - 15%) compared to the growth in number of troops served (60 - 170%) is worth noting. (While the number of troops represents mean strength and not, as in the case of personnel, total strength at the end of the year, the two figures are roughly comparable, as the trend of troop strength was generally upward in all three service commands). This is not, however, necessarily attributable to the saving of effort produced by reorganization, since a relatively small increase of personnel also occurred between 1940 and 1941. Moreover the reorganization to some extent merely shifted duties from the medical branch to other fractions of service command headquarters, so that if effort was saved in the medical branch an expenditure may have been necessary somewhere else.

NOTES FOR CHAPTER IX

[1] WD Circular 59, 2 March 1942.

[2] Wadhams Committee, pp. A20, 169; letter, CG, SOS, to CG's, all service commands, SPCG 323.3(7-22-42), 22 July 1942.

[3] Service Command (formerly corps area) Reorganization, 22 July 1942, p. 29; Service of Supply Organization Manual, 10 Aug 1942, Part IV, 400.00.

[4] Wadhams Committee, p. 169.

[5] General Orders No. 25, Headquarters SOS, 22 July 1942.

[6] SOS Organization Manual, 10 August 1942, Part IV, 400.00.

[7] SOS Organization Manual, 10 August 1942, Part IV, 403.00, 403.02; Wadhams Committee, p. 169.

[8] SOS Organization Manual, 10 August 1942, Part IV, 400.00, 400.00 2.

[9] Ibid., 405.00.

[10] Ibid., 405.05.

[11] SOS Organization Manual, Part IV, (Revision No. 1) 24 December 1942, 405.00.

[12] SOS Organization Manual, Part IV, 10 August 1942, 405.00.

[13] This Chart shows no change in the position of the medical branch.

[14] Ibid., Revision of 24 December 1942, 405.00.

[15] Memo for the SG from Acting Chief of Staff, ASF, 2 September 1942 (Record Room, SGO, 323.3-2 [6th Service Command] AA).

[16] Annual Report, Sixth Service Command, 1943, (Historical Division, SGO).

[17] SOS Organization Manual, 10 August 1942, and revision of 24 December 1942, 405.01.

[18] SOS Organization Manual, 10 August 1942, 405.05 3.

[19] Annual Report, Second Service Command, 1942 (Historical Division, SGO).

[20]SOS Organization Manual, Revision of 24 December 1942, 405.05/2, 405.05/5.

[21]History, Office of the Second Corps Area and Second Service Command (Historical Division, SGO).

[22]Annual Report, Second Service Command, 1942 (Historical Division, SGO).

[23]SOS Organization Manual, 10 August 1942, 402.02.

[24]History, Office of the Second Corps Area and Second Service Command (Historical Division, SGO).

[25]Surgeon, Sixth Corps Area to SG, 9 May 1942 (Record Room, SGO, 337.-1).

[26]Headquarters SOS to all Corps Area Commanders, 26 May 1942 (Record Room, SGO, 020.-1).

[27]Memo for Mr. Carrington Gill from Brig. Gen. C.C. Hillman, 2 October 1942 (Record Room, SGO, 701.-1).

[28]Annual Report, Seventh Service Command, 1942 (Historical Division, SGO).

[29]Annual Reports of First, Third, Eight Service Commands, 1942 (Historical Division, SGO).

[30]Annual Reports, First and Eighth Service Commands, 1942 (Historical Division, SGO).

[31]WD Circular No. 59, 24 Feb 1943.

[32]Annual Reports, Second, Third, and Eighth Service Commands, 1942 (Historical Division, SGO); Wadhams Committe, p. 428.

[33]Annual Report, First Service Command, 1942 (Historical Division, SGO).

[34]Annual Reports, Third and Eighth Service Commands, 1942 (Historical Division, SGO).

[35]Annual Report, Second Service Command, 1942 (Historical Division, SGO),

[36]Annual Reports, Second, Third, and Eighth Service Commands, 1942 (Historical Division, SGO).

CHAPTER X

CRITICISM AND READJUSTMENT 1942 - 1943

Opinions on the Reorganization of 1942

The new status of the Medical Department in the service commands did not meet with unanimous approval. Its principal defender was Headquarters, Services of Supply; the chief criticism came from The Surgeon General's Office. This difference of opinion was aired in testimony before the committee to study the Office of The Surgeon General (the so-called "Wadhams Committee") in September 1942. At that time the representative of Services of Supply held that the new organization had definitely expedited business, and that the service command could make decisions in 90 per cent more cases than before. A witness from The Surgeon General's Office, on the other hand, pointed out that the former Corps Area Surgeon

> is now a branch in some corps area Personnel Division; in other corps area/s/ most of them are /in/ the Supply Division, /in/ still another corps area the functions of his office are scattered all through the service command organization, and since personnel is in the Personnel Division, and supply is in the Supply Division, hospitals and evacuations in the Training Division . . . as a result we haven't a corps surgeon in the sense we used to have.

If the organization chart was followed, he added, "you have two lay minds superimposed between /upon?/ a professional."[1]

Before the Wadhams Committee issued its recommendations The Surgeon General himself stated the argument more coherently. In a memorandum to the Commanding General, Services of Supply, he maintained that recent directives from Headquarters, Services of Supply, required that the service command medical branch "be, in effect, disintegrated by the assignment of members to the several divisions of the Headquarters Staff, thereby removing them from the direct supervision and control of the senior medical officer." This dispersion, he said, "tends to hinder rather than help the operations of the Medical Department," a fact which in his opinion was clear from the testimony and conversation of several senior medical officers of the service commands.

> Too much depends upon the mere maintenance of amicable personal relationships within the service command headquarters, rather than

upon an organization setup whereby the senior military officer may have the authority and staff to discharge his responsibilities in the most efficient manner.

He therefore proposed a thoroughgoing change of status for the medical branch:

> In consideration of the great extent and importance of the service commands, the peculiarities of technical control inherent in the operations of a medical service, and because of the supreme interest felt by the people of the nation on the welfare of American troops, it is recommended that in each service command headquarters the entire personnel pertaining to the Medical Department (except civilian personnel) be assembled under the direct control of the senior medical officer and that his office be established on a Divisional level on the Staff of the Commanding General [of the service command].[2]

The reply to this proposal was an indorsement only in the technical sense. The Commanding General, Services of Supply, answered that the transfer of the hospitalization, evacuation, and sanitation functions from the supply division to the personnel division of service command headquarters would "in no sense 'disintegrate' the medical activities at Headquarters." (It will be remembered that this particular change had been introduced shortly after the publication of the first organization manual, which had assigned medical functions to the supply division.) The only medical functions still retained by the supply division, he continued, were matters of medical supply, which were "minor in character since local procurement of medical supplies is handled at posts and in small amounts." Otherwise,

> this is exactly the same situation as existed previously. . . The Chief Medical Officer will have direct access to the Service Commander on all matters relating to the health of the Command. . . Under the above organizational arrangement, I fail to see how the technical activities of the medical department will suffer. It is my desire that this plan be given a fair trial with full cooperation and support from your office.[3]

Much later the Surgeon of the Second Service Command remarked that this transfer of the medical branch to the personnel division was "an even more unsatisfactory organi-

1 (

zational arrangement than under the Supply and Services Division."[4] The new arrangement, in fact, did not long persist. As has already been mentioned, the organization manual of 24 December 1942, not much more than six weeks after the exchange of letters, restored the medical branch to the supply and service division.

However, the larger issue of raising the medical branch to divisional level, directly responsible to the service commander, continued to be a subject of debate. The Surgeon of the Third Service Command, it is true, reported that

> placing the medical branch in the supply and service division has not interfered with the operation of the Medical Service. The surgeon still has direct contact with the Commanding General and Chief of Staff on matters directly affecting the health of the command. Authority for chiefs of sections in the medical branch to sign communications in the name of the Commanding General has expedited forwarding of communications and reports. It is the opinion of the undersigned [Chief of the Medical Branch] that the reorganization of the Service Command Headquarters and of the Surgeon's Office has increased the efficiency of the medical service.[5]

Affairs were not arranged so amicably in the Fourth Service Command. On 1 January 1943 the Chief of the Medical Branch addressed a letter to the Service Commander pointing out that matters affecting medical personnel were divided between the Medical Branch and Military Personnel Branch, that the latter had been given eighteen of the twenty persons engaged in medical personnel work, and that the Medical Branch was communicated with,"usually by telephone," for the purpose of requesting station assignments. This, it was alleged, permitted division of authority and responsibility, caused delay and unnecessary duplication of work, and was "confusing, irritating and altogether unsatisfactory." Since, according to the new organization manual, the Chief of the Medical Branch was a personal advisor to the Service Commander on all matters concerning the health of personnel, and since proper care of health depended largely on the qualifications of medical personnel, it was recommended that all activities of the Medical Department Personnel Division should be returned to the Surgeon and placed directly under his control. The Chief of Staff referred this communication to the Director of the Personnel Division. The latter replied that the matter had again been investigated "as on three or four previous occasions." The agreement to refer certain matters by telephone, he added, had been made "in the interest of

harmony rather than because of necessity to mollify the surgeon who was bitterly opposed to compliance with directions from Headquarters, SOS, and also this Headquarters." He admitted that faults existed, but they were "primarily in the mind of the Surgeon. . . The former system was tried, found wanting and condemned by the Commanding General, SOS." To this analysis of his recommendation and motives the surgeon responded in a letter to the Chief of Staff, assuring him he was aware that no change in the existing order could be made without War Department authority; his purpose was merely to inform the Commanding General that the present system was not efficient. He also noted that "this office does not appreciate the general tone of the remarks" made in the answer to his letter. After this exchange the Surgeon forwarded copies of the correspondence to The Surgeon General's Office with the comment: "You will notice we got nowhere in a Hell of a hurry. I am going to keep pounding at them, and hope some day to be able to run the Medical Department as efficiently as it could be if they would let us handle our own business."[6]

Meanwhile the Wadhams Committee finished its inquiry and made its recommendations. The Commanding General, Services of Supply, sent these proposals to The Surgeon General's Office for comment. Of the ninety-eight recommendations only one need be mentioned here. It proposed that "within each service command there should be a unified Medical Division the Director of which should be on the staff of the Service Commander in charge of all medical activities." This merely repeated the recommendation already submitted by The Surgeon General himself as described above (p. 126). The Surgeon General's Office therefore simply referred to this earlier correspondence, a copy of which it attached, and remarked that "since this recommendation was disapproved, this office will cooperate in every way to make this organization work." (Incidentally these comments seem to have been prepared by some person or persons other than The Surgeon General, as the only remark appended to another recommendation is that "in the absence of The Surgeon General from this country, comments are omitted.")[7]

A New Status for the Service Command Surgeon

Undeterred by the setback which his predecessor had received, a new Surgeon General renewed the campaign to raise the status of service command surgeons. On 14 June 1943, shortly after taking office, Major General Kirk assembled a conference of chiefs of service command medical branches to discuss their problems. "Recently," he reported to this meeting,

> I had a talk with General Somervell [Commanding General, Army Service Forces] and from

> what I heard it struck me that we had more or less lost control in the service commands as far as the Medical Department was concerned and that the job there was being done on personalities and not on organization. I asked him if he would entertain a proposal that we might bring to him as to where we thought the surgeon of the service command should be and his relation to the Commanding General of the service command in order to carry out the responsibilities placed on The Surgeon General of the Army. I told him what I thought these responsibilities were and that everybody knows we couldn't carry on unless we had authority. He then suggested that you come here for a conference.

The Surgeon General also announced that "we will appoint a board to study this and submit a report," the board to consist of three members assisted by the Chief of the Control Division, Army Service Forces.[8]

Three days later (17 June 1943) the board, or committee, made its report to The Surgeon General. The committee stated that after consultation with the chiefs of the nine service command medical branches it believed certain changes must be made in the Service Command and Air Force organization for the care of the sick, if The Surgeon General was to carry out his mission for the entire Army. The changes needed were two in number:

> First, place the Medical Service of the Service Command on the same level as other Divisions of the Service Command instead of subordinating it as a branch operating under one Division when it has varied relations with all Divisions. Second, place the responsibility upon the Service Commander for all medical service including hospitalization, evacuation and sanitation of all fixed installations within the geographical limits of the Service Command.

"This," the committee pointed out, "will relieve the Army Air Forces of all medical service functions at fixed installations and permit it to devote its time and personnel to tactical and combat problems, the same as is now done for the Army Ground Forces." The report presented a list of textual changes to be made in the organization manual for the purpose of carrying out these recommendations. One such change specifically mentioned the training responsibilities of the service command medical division, the first time such

a direct statement would have been introduced into the manual. The medical division, the proposed clause read, "supervises Service Command training activities relating to medical units in accordance with training policies of the Training Division [of the Service Command]."[9]

The Surgeon General sent this report to the Commanding General, Army Service Forces, expressing the belief that the service command surgeons could not carry out their responsibilities to The Surgeon General unless they had control of Medical Department personnel, hospitalization and evacuation, and training, "the latter applying particularly to Medical Department A.S.F. overseas units." At the recent conference, he said, "it was found that there was not a uniformity of procedure. Some [surgeons] are operating more or less under the above plan while others are able to function because of personal contact rather than basically sound organization. It is believed that the Medical Branch should become a Division, operating under the Chief of Staff."[10]

In reply, the Commanding General, Army Service Forces, expressed himself as "favorably disposed towards the plan." But before putting it into effect he wanted the views of the service commanders and for that purpose was sending them copies of the plan in preparation for a discussion at the forthcoming Service Command Conference.[11]

The conference met in Chicago on 22 July 1943. In his opening remarks the Commanding General, Army Service Forces, spoke of the position of the service command surgeon as one of the topics to be discussed. However, only one of the service commanders, in their formal speeches to the conference, referred to the subject. The Commanding General of the First Service Command

> recommended that the Medical Branch of the Supply and Service Division be made a separate division, and that all medical service for all fixed installations, including Air Forces installations, within the service command be made the responsibility of the service commander. Unification of control and training of medical personnel appear clearly desirable.[12]

The Surgeon General restated his own position in the matter. He drew attention to his relation as a staff officer to the Commanding General, Army Service Forces, and suggested that the service command surgeon be given the same status with respect to the service commander, namely that of a division chief answering directly to the latter. So placed, the surgeon could render better service. "In some service

commands," he pointed out, "Medical Department personnel constitutes approximately 50% of the total duty personnel. The duties of the Medical Department concern all of the other staff divisions and the senior medical officer should be in a position to deal direct with these division heads." He urged the service commanders to consult their senior medical officer on all medical matters. At present he might or might not be consulted as to assignments. While the personnel division was charged with the assignment, transfer, reassignment and promotion of Medical Department personnel, "no one except a senior Medical Department officer is qualified to interpret or judge the professional qualifications of individual officers, nurses, dietitians and physical therapists . . . to determine and evaluate their ability for special assignment to duty." The same applied to a less extent to medical department enlisted men. Likewise, the technical character of medical training required that its inspection and supervision should be a matter of close cooperation between the heads of the medical, personnel, and training divisions. "We are not," he concluded, "asking for more authority or power, but for an organization that makes for efficiency."[13]

Toward the end of the conference a hint was dropped that the decision on The Surgeon General's main proposal would be unfavorable. The Deputy Chief of Staff for service commands, Army Service Forces, remarked that every branch chief would naturally prefer to deal directly with the service commander, and that if one technical branch was raised to division level the others would feel entitled to the same elevation. But the purpose of the original reorganization had been to keep the number of primary divisions at a minimum and the machine had grown too big to depart from the principle now. However, he could not imagine a division chief's neglecting to take the appropriate branch chief with him when called in to advise the service commander.[14]

In his summary remarks at the end of the conference the Commanding General, Army Service Forces, gave his promised decision in the matter. It was adverse to The Surgeon General:

> I am going to disapprove the recommendation that the senior medical officer in each service command be established in a position where he reports direct to the commanding general of the service command. If I did otherwise there would be equal reason to put all the other service chiefs in exactly the same fix, and we should lose all the benefits that we have gained so far. . . . I do not want to suggest any changes in your organizations. You have been through a number of those, and I hate

> to suggest any others. . . Certainly you have got to talk to your doctor. You have got to know what he has to say, and I expect you to do that. But for the moment I do not want to say anything more.[15]

The last sentence perhaps conveyed a suggestion that the question might be reopened at some future date. If so, it was almost the only crumb of satisfaction the The Surgeon General could carry away. Almost, but not quite, for there was no doubt that the Commanding General, Army Service Forces, and his deputy for service commands considered as highly essential the maintenance of close contact between the service commander and his surgeon, no matter what the formal organization might be.

Other matters which also directly or indirectly concerned the position and functions of the Medical Department in the service commands were discussed at the Chicago conference. One such point was the question of medical service at Air Force installations, which will be dealt with later on.[16] Another was the relationship between The Surgeon General and the service commanders. The Director of the Control Division, Army Service Forces, in describing the position of the technical services in Washington with respect to the service commands, used The Surgeon General's Office as his illustration. The Surgeon General, he pointed out, "is the senior authority in the Army in all matters medical." If the service commander was dissatisfied with the medical personnel in his command, he should take up the matter with The Surgeon General, and vice versa if The Surgeon General found the medical service inadequate in a service command. "Between the two of them they should be able to find the proper man for the job." If not, the next step was to enlist the aid of the Director of Personnel, Army Service Forces. Still failing to reach a solution they might put the matter up to the Commanding General, Army Service Forces, "who, I am sure will reach a decision. Now this sounds like A,B,C, but it is the violation of this very simple method of operations that is responsible for nine-tenths of the difficulties between the technical services in Washington and the service commanders."[17]

Some days after the Chicago conference, the Surgeon of the First Service Command wrote to The Surgeon General sympathizing with him on the failure of higher headquarters to create a division status for the medical branch. "You put up a real fight for it, and we can function efficiently despite the present organization." The Surgeon General's reply showed that he had by no means given up hope. "I believe," he wrote, "that eight out of the nine service commands would have gone along with us and /I?/ have been told

that General Somervell himself hasn't his mind made up and it may yet come through. This was told me by somebody pretty close to him."[18]

The Surgeon General's informant was correct. Three months afterward, on 12 November 1943, a letter to all service commanders from Headquarters, Army Service Forces, announced a desire that "the headquarters of each service command be made to conform as closely as practicable to the organization of the Headquarters, Army Service Forces . . . by 15 December 1943."[19] A new organization chart and list of functions was attached. On the chart the "service command surgeon" (now officially so called for the first time), together with the chiefs of other technical services, had a line of communication direct to the service commander and his chief of staff. Though still not technically a division (a term reserved for certain other "staff" elements), the surgeon's office no longer formed part of the supply division, but stood on an equal footing with it from the standpoint of command. Certain changes were made in the statement of functions, partly to conform with this new position. Thus it was no longer necessary to state that the surgeon was directly responsible to the service commander when acting as an advisor on all matters concerning the health of personnel. And since the surgeon's office was now separated from the supply division its supply functions had to be specified. These two matters were taken care of by sections stating that the service command surgeon

> (1) Supervises the performance of all functions relating to medical activities which are the responsibility of the service command, including the procurement, distribution, issue, storage, inspection, maintenance, repair, replacement, and reclamation of medical supplies and equipment, and the provision of hospitalization and medical and veterinary service.
>
> (2) Supervises and renders technical advice on all medical activities under the jurisdiction of the service commander.

However the supply division kept its responsibility for "insuring the proper performance of service command activities relating to the storage, issue, distribution, maintenance, and repair of supplies and equipment."

The former provision regarding personnel was strengthened. Besides making "recommendations for the assignment and transfer of medical personnel within the service command," the surgeon now in addition "supervises the proper utilization of the

specialties and technical qualifications of such personnel." The personnel division, while still charged with arranging for the selection and placing of all military personnel, was to make its assignments hereafter "upon recommendation of service command Technical Services" (including the surgeon's office).

How this collaboration might be worked out was indicated in a memorandum from the Director of the Control Division, Army Service Forces, to The Surgeon General:

> The Director of Personnel should handle the mechanics of paper work of assignments of medical personnel in the same manner as is done for all other personnel in the service command. In all cases, however, before any assignments of medical personnel are made, the recommendations of the Service Command Surgeon should be secured and these recommendations should be followed unless they are contrary to general policies laid down to the Director of Personnel by the Service Commander. In addition the Service Command Surgeon should initiate action to assign and reassign medical personnel, using the office of the Director of Personnel for implementing such actions. The Director of Personnel should maintain such records on medical personnel as he maintains on all personnel under the jurisdiction of the Service Commander. Special records of medical personnel, particularly with respect to qualifications and specialties can be maintained either under the Director of Personnel or under the Service Command Surgeon, depending upon which is the most convenient method of operation in view of physical location and other factors.[20]

The new organization described in the memorandum of 12 November 1943 was not intended to be the final and unalterable plan. A week later the Chief of Staff, Army Service Forces, addressed letters to the nine service commanders asking for suggestions which might be embodied in the final draft. He notified them, however, than one matter was beyond dispute: "It should be borne in mind that a decision has already been made to have Technical Service units in the Service Command Headquarters correspond to the Technical Services in our Headquarters in Washington." In other words, the position of the service command surgeon and his colleagues was now definitely changed to one of direct responsibility to the service commander.[21]

At least one service commander did not wait for further orders. The Commanding General of the Fifth Service Command reported that the reorganization had been effected in his command on 27 November.[22]

A second version of the plan appeared on 8 December, the final date for compliance being pushed back to 31 December 1943. It contained one addition and one revision affecting the service command surgeon. A statement was inserted that

> the Technical Service officers [including the surgeon] of the Service Command supervise the performance of activities of the seven Technical Services of the Army Service Forces in the service commands and act as technical advisors to the Commanding General and to the staff agencies in the establishment of policies and procedures pertaining to these activities. In the performance of these duties the Technical Service officers will function in the manner established for staff elements in Sections 103.03 and 103.04, Part I, Army Service Forces Organization Manual, 15 July 1943.

The sections referred to specified as staff functions the rendering of advice to the commanding general; the formulation of plans, policies, and procedures; the rendering of advice and assistance to subordinate components; and the constant "follow-up" on performance throughout the organization--all of course pertaining to a particular field of responsibility such as medical service.

The revision now introduced affected the veterinary aspect of the surgeon's responsibility. He still supervised "all veterinary inspections incident to the procurement of meat and food supplies within the service command," but whereas previously he might, at the Quartermaster General's request, assist in inspecting other procurements of meat and food, the Quartermaster General was now made responsibile for "all veterinary inspections within the Quartermaster Depots and within the metropolitan area in which the respective Quartermaster Depot is located."[23]

The plan of 8 December was included in the new organization manual of 15 December 1943 without further changes affecting the service command surgeon (see Chart XXII).

The realignment accomplished some of the objectives for which two Surgeons General, as well as a number of service command surgeons, had been striving since 1942, although one service command did not conform to the new plan until 1945.[24] The surgeons were again, as they had been before the reorgani-

zation of 1942, essentially staff members. This conflicted, at least superficially, with the principle of increasing decentralization which the Commanding General, Army Service Forces, had insisted upon. But the service command structure now more truly reflected that of Headquarters, Army Service Forces, since the surgeon's office, as well as the other technical services, answered directly to the commanding general instead of reporting to an intermediary such as the director of supply.

At the Chicago conference in July 1943 the Commanding General, Army Service Forces, had called attention to the "tremendous strides" made in decentralizing authority from his Headquarters to the service commanders. But "I am not so sure," he remarked, "that the same decentralization has been passed to post commanders. Most of you assure me that it has. I would just like for you to check on that a little and find out to what extent this has been done."[25] The new organization chart for post headquarters, however, retained the same structure as the previous one. It was more elaborate, but it still showed the post surgeon and the other technical staff members reporting directly to the post commander. Post headquarters were to become practically copies in petto of service command headquarters, as the chart for 15 December 1943 indicates (see Chart XXIII).

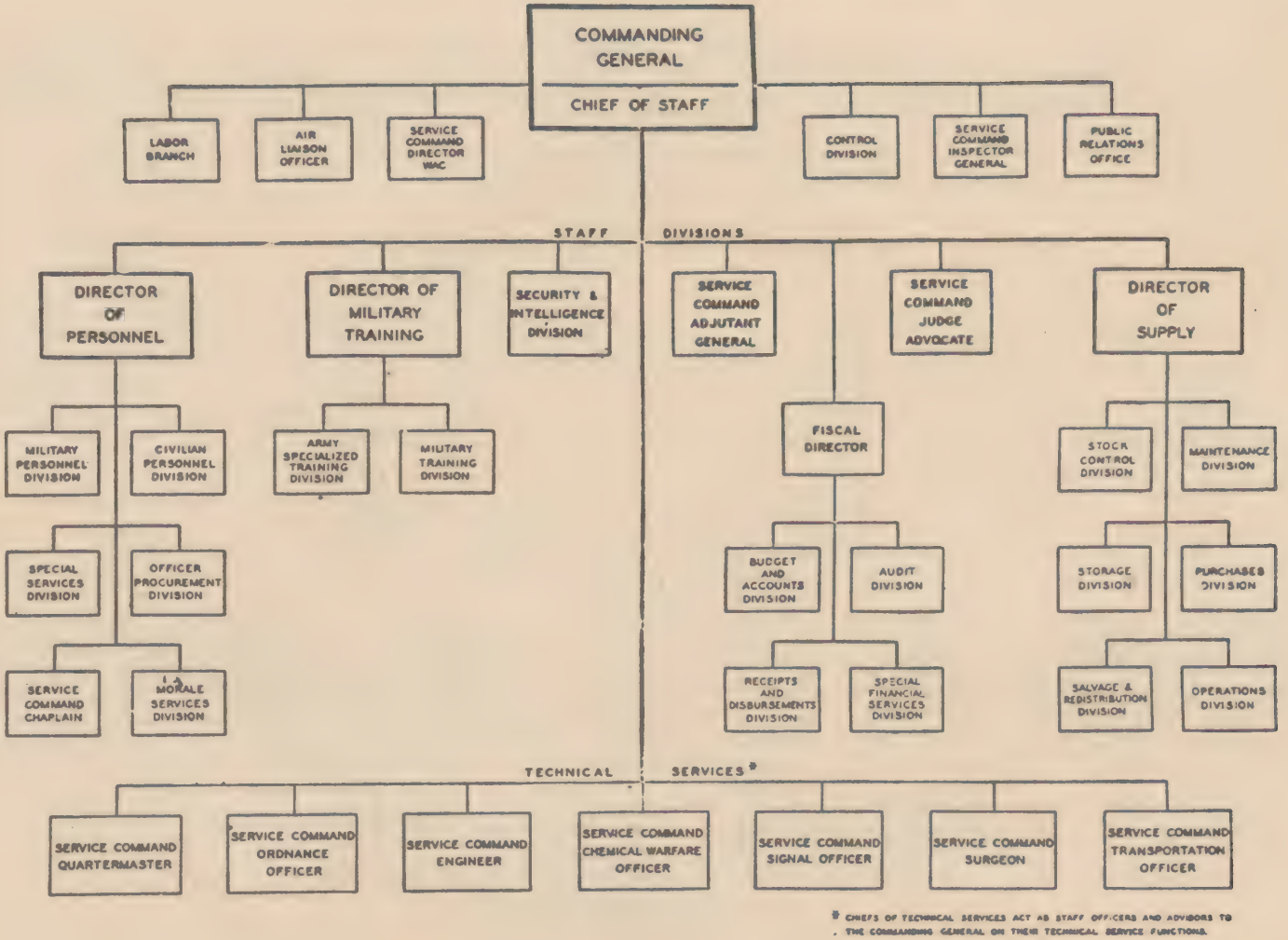
Internal Organization of the Service Command Surgeon's Office

While the recasting of service command headquarters was being planned, a model for the surgeon's office was also constructed for presentation to the Service Command Surgeons Conference called by The Surgeon General on 10 December 1943 (see Chart XXIV). It was "considered desirable that the office of each service command surgeon be organized in a manner approximating that of The Surgeon General of the U. S. Army," with services responsible for administration, personnel, medical supply, and professional care. The plan contained detailed suggestions as to the internal arrangements of each division. For example, it was proposed that the service command surgeon should himself act as chief of professional service, and that the divisions of medicine, neuropsychiatry, and nutrition should be headed by the consultant assigned to each of these particular fields. Each division chief would deal directly with the service command surgeon.[26]

In his annual report for 1943 the Surgeon of the Sixth Service Command stated that his office had been organized "approximating that of The Surgeon General," and indicated that most of the above suggestions had been carried out.[27] The available evidence is insufficient to indicate whether or not the other service commands followed this example (before the end of 1943). At that time the surgeon's office, Second

SERVICE COMMAND HEADQUARTERS

ORGANIZATION OF SERVICE COMMAND HEADQUARTERS

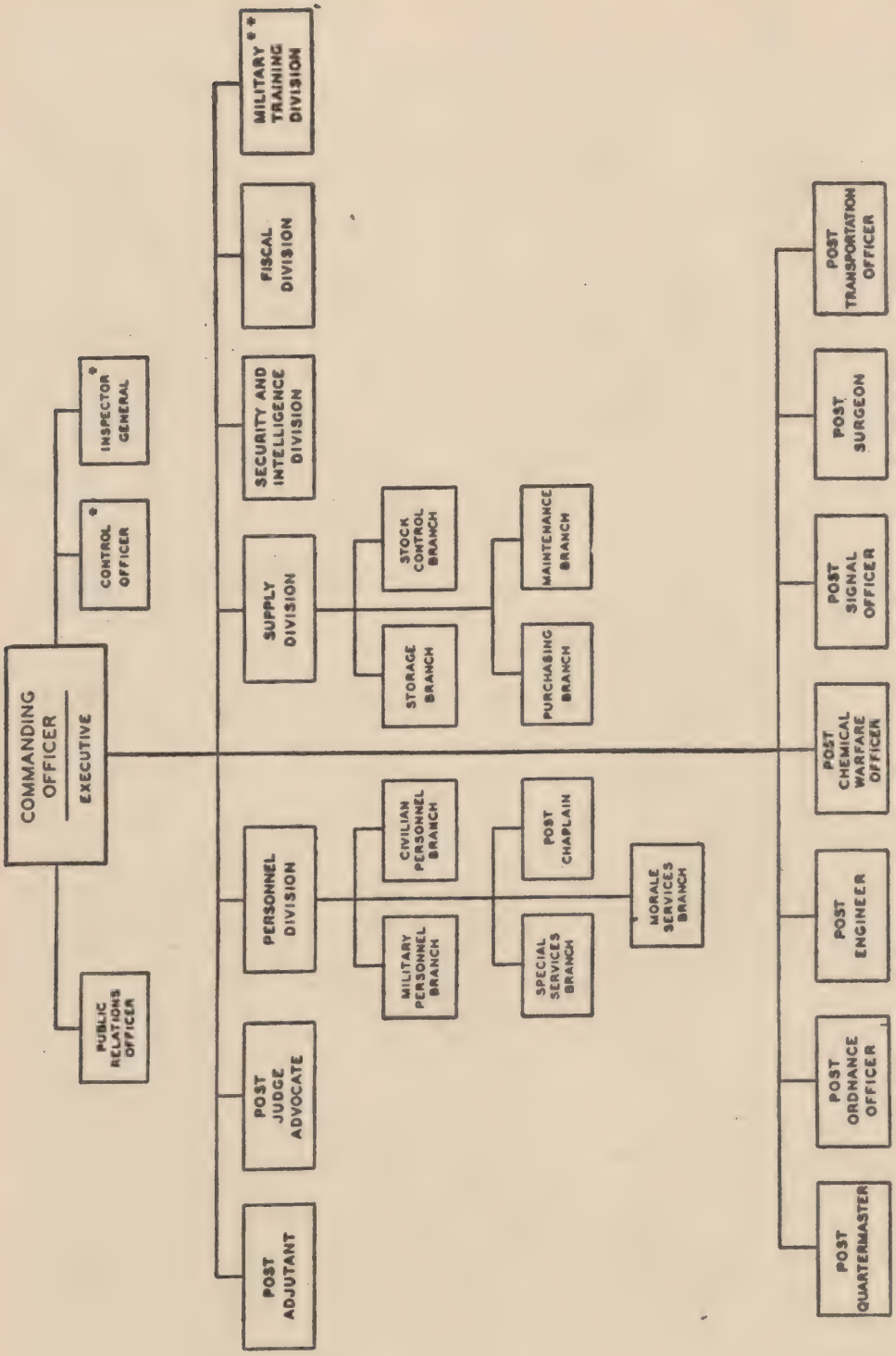


* CHIEFS OF TECHNICAL SERVICES ACT AS STAFF OFFICERS AND ADVISORS TO THE COMMANDING GENERAL ON THEIR TECHNICAL SERVICE FUNCTIONS.

Chart XXII

Revised 15 Dec 1943
465.00A

POST ORGANIZATION CHART



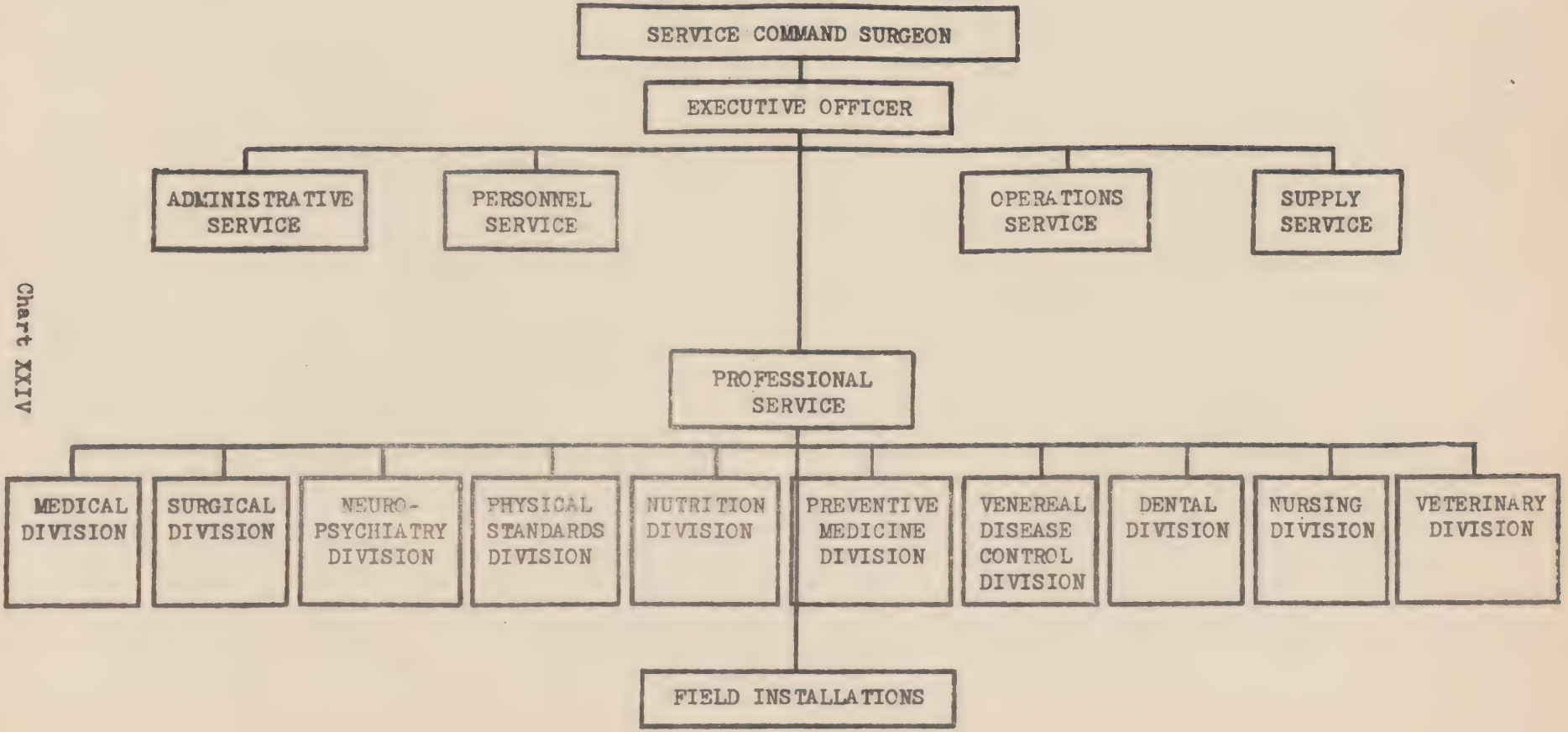
**May be placed under Personnel Division if special circumstances do not warrant a separate division.

*May not be necessary in small installations.

Chart XXIII

Chart XXIV

ORGANIZATION OF SERVICE COMMAND SURGEON'S OFFICE



(Copy of chart from "The Surgeon General's Conference with Service Command Surgeons. To be held in the Office of The Surgeon General, Commencing December 10, 1943.")

Service Command, still retained the same nomenclature for six of its seven main subdivisions as earlier in 1943 (above, Chart XXI), having merely dropped the training section and added a personnel branch. The Eighth Service Command also showed little variation from its set-up of 1942 (above, Chart XIX), and the changes made had nothing to do with the events of late 1943. Thus in March 1943 the Procurement and Assignment of Personnel Subsection (Plans and Training Section) was redesignated Assignment Section and charged with the assignment of Medical Department officer personnel. In the same month a Hospitals and Hospitalization Section was created, made up of the administrative portion of the Medical Education Program and the Hospital Construction and Campsite Subsections of the Plans and Training Section. The Plans and Training Section disappeared. The Consultants Section was redesignated the Professional Services Section in July 1943. However, as we shall see, the office underwent further remodeling before the end of 1944, which brought it more into conformity with the layout of The Surgeon General's Office.[28]

Apparently the reorganization of service command headquarters did not necessarily affect the structure or even the business of the surgeon's office. This may seem strange in view of the restatements of functions contained in the directives and organization manual of December 1943, but it was probably because techniques had already been worked out in individual service commands which anticipated these directives. There may have been other reasons also: perhaps the authorities in some service commands were slow in adopting the new interpretations or saw in them nothing essentially new. Thus the Surgeon of the Sixth Service Command stated positively that the manual of December 1943 made no changes in his functions or activities. Nevertheless, as we have seen, he announced the reorganization of his office to conform to that of The Surgeon General.[29]

The Question of Air Force Installations

While the status of the service command surgeon with respect to the service commander was under discussion and revision, the surgeon's authority in Air Force installations remained a subject of debate. Circulars and directives issued in 1942 and 1943 did not settle the matter completely. The recommendation of The Surgeon General's committee, already referred to (above p. 129), had been anticipated a few days previously by The Surgeon General himself. At the conference with service command surgeons in June 1943 he stated the question in broad terms:

> The Air Corps operates some 250 hospitals in the Zone of the Interior. . . We think that all Army hospitalization should be under one

> control. It all belongs under the service commands and we hope to take all that over. The Flight Surgeon has a very definite place as a specialist and he'll write the prescription on all flying personnel training and flying. We will treat the fractured leg, hernia or what not, and when we finish with them they will be turned over to the flight surgeon for reconditioning and to be kept in flying condition. We'll see that [the Flight Surgeon] has the necessary facilities--swimming pools, golf courses, bands, or anything else he wants, and give him all we can.[30]

The subject came up again a month later at the Chicago conference of service commanders. The Commanding General of the Eighth Service Command advocated the abolition of all exempted stations and the concentration of responsibility for all service functions in the service commanders. He considered The Surgeon General's proposal

> an important step in this direction. Such action would make it possible to supply medical service to both Class II and III [Ground and Air Forces] installations with less personnel and with better utilization of the specialized abilities of the medical officers available in the area. The service commander has responsibility for sanitation in [Air Forces] installations, but he has no responsibility for the care of the sick and wounded. I think you will agree that a duplication of personnel and an uneconomical use of professional personnel is inevitable.

While the Air Forces had no general hospitals, he added, there existed two pools of medical personnel within the service command, over one of which the latter had no control.

The Surgeon General reported that he had "not made much headway" with his proposal to take over the 250 Air Forces station hospitals, but that certain kinds of cases would be transferred from Air Forces hospitals to general hospitals.

A spokesman for the Air Forces admitted lack of information on hospitals but thought that "these differences should be solved," and that "it is a matter of personalities, probably in the lower echelons, because . . . we haven't had any difficulties from the service commands."[31]

However, the Surgeon of the Second Service Command reported at the end of 1943 that his limited supervision of medical activities in Air Forces installations and certain of the Army Service Forces installations controlled from Washington "made it quite difficult to provide that degree of overall medical care considered as most desirable and most likely to meet the continuing objectives of the War Department concerning conservation of personnel and facilities."[32]

One particular difficulty arose over the activities of medical consultants who were assigned to the offices of service command surgeons but who also operated in Air Forces installations. The matter had been brought up in testimony before the Wadhams Committee in 1942. At that time the chief of The Surgeon General's Medical Practice Division stated that while the Air Corps sometimes cooperated, and while "of course we feel perfectly free to go into Air Corps hospitals," there was "some uncertainty--in view of conflicting directives -- . . . on the part of service command surgeons as to their responsibilities and prerogatives in this matter."[33]

A War Department circular of 6 December 1943 stated that "these consultants will be made available to the medical installations not under control of the service command. Their visits will be made in accordance with arrangements agreed upon between the commands concerned."[34] This did not, however, resolve all difficulties. In February 1944 the Surgeon of the Fourth Service Command transmitted to The Surgeon General a document which he described as "distasteful to the service command consultants." This was an extract from a medical bulletin issued by the Surgeon of the Third Air Force, which "reminded" station hospital surgeons that service command consultants were

> limited specifically to professional matters of a technical nature. These visits are not a military inspection. Consultants will be given only such data as directly relate to the specific technical problem for which consultation was requested. Information regarding strength, number of professional personnel, general administrative procedures, etc., will not be given. Station surgeons will carefully scrutinize reports of consultants and when the contents of the report cover any phase of hospital administration other than the technical problem specifically under consultation, exception will be taken in the indorsement and channelled to this office for action.

The Surgeon General answered that the relation of consultants to Air Forces station hospitals was under study and that

"something definite" would result. "I think this will change things materially. Let them run their installations the way they want if you desire and use your consultants where their work will be appreciated."[35] A new War Department circular dated some weeks later merely stated that the technical reports of consultants would be forwarded to The Surgeon General through medical channels within the Army Ground Forces, Army Air Forces, or Army Service Forces.[36] This changed the previous rule, under which the consultant's report on an Air Forces installation was sent through command channels to the Commanding General, Army Air Forces, an information copy going to the service commander for the attention of his surgeon.[37]

Having discussed the changes in organization of the service command surgeon's office as they developed to the end of 1943, we may now return to the subject of hospital organization during the remainder of the war and the period immediately following it.

NOTES ON CHAPTER X

[1]Wadhams Committee, pp. 46-47, 192.

[2]Memo from Maj. Gen. J. C. Magee for Lt. Gen. Somervell, 7 Nov 1942 (Record Room, SGO, 323.3-2).

[3]Ind. to above, Lt. Gen. Somervell to Maj. Gen. Magee, 12 Nov 1942, loc.cit.

[4]History, Office of the Second Corps Area and Second Service Command (Historical Division, SGO).

[5]Annual Report, Third Service Command, 1942 (Historical Division, SGO)

[6]Col. S. W. French to Col. G. F. Lull, 13 Jan 1943 (Record Room, SGO, 323.3-2 /4th Service Command/).

[7]Wadhams Committee, Recommendations No. 58 and 62 (Historical Division, SGO).

[8]Report of Surgeon General's Conference with Chiefs, Medical Branch of Service Commands, 14-17 Jun 1943 (Record Room, SGO, 337.1).

[9]Memo for The Surgeon General from Cols. W. Lee Hart, E. C. Jones, and C. M. Walson, 17 Jun 1943 (Record Room, SGO, 300.7-1).

[10]Memo for the CG, ASF, from the SG, 18 Jun 1943 (Record Room, SGO, 300.7-1).

[11]Ind. to above, undated, loc.cit.

[12]Army Service Forces Conference of Commanding Generals Service Commands, 22-24 Jul 1943, pp. 6, 77 (Record Room, SGO).

[13]Ibid., 128, 131-132.

[14]Ibid., 348.

[15]Ibid., 381.

[16]Below, p. 137.

[17]Ibid., p. 99.

[18]Col. J. J. Reddy to Major Gen. Kirk, 4 Aug 1943; Major Gen. Kirk to Col. Reddy, 7 Aug 1943 (Record Room, SGO, 323.3-2 /1st Service Command/ AA).

[19]Headquarters, ASF, to Commanding Generals, all Service Commands, 12 Nov 1943 (Record Room, SGO, 323.3-2).

[20]Memo for SG from Director, Control Division, ASF, 13 Nov 1943 (Administrative Records, CG, ASF, 321 /Service Commands/).

[21]Maj. Gen. Styer to CG, First (etc) Service Command, 19 Nov 1943 (Administrative Records, CG, ASF, 321 /Service Commands/).

[22]CG, 5th Service Command to CG, ASF, 1 Dec 1943, loc.cit.

[23]Headquarters, ASF, to CG's, all Service Commands (Record Room, SGO, 323.3-2).

[24]Information from Col. R. J. Carpenter, Executive Officer, Surgeon General's Office.

[25]Army Service Forces Conference of Commanding Generals Service Commands, 22-24 Jul 1943 (Record Room, SGO).

[26]The Surgeon General's Conference with Service Command Surgeons to be held in the Office of The Surgeon General, commencing 10 Dec 1943 (Record Room, SGO, 337.-1). Apparently this is the agenda for, not a report of, the conference.

[27]Annual Report, 1943, Sixth Service Command (Historical Division, SGO).

[28]Annual Reports, Second and Eighth Service Commands, 1943 (Historical Division, SGO).

[29]Annual Report, Sixth Service Command, 1944 (Historical Division, SGO).

[30]Report of Surgeon General's Conference with Chiefs, Medical Branch of Service Commands, 14-17 Jun 1943 (Record Room, SGO, 337.1).

[31]Army Service Forces Conference of Commanding Generals Service Commands, 22-24 Jul 1943, pp. 250, 251, 255 (Record Room, SGO).

[32]Annual Report, Second Service Command, 1943 (Historical Division, SGO).

[33]Wadhams Committee, p. 435 (Historical Division, SGO).

[34]WD Cir. 316, I, 2b(2)(b), 6 Dec 1943.

[35]Col. French to Major Gen. Kirk, 22 Feb 1944; Major Gen. Kirk to Col. French, 28 Feb 1944 (Record Room, SGO, 323.3-2 /4th Service Command/ AA).

[36]WD Cir. 140, 2d 11 Apr 1944.

[37]WD Cir. 316, I, 2b(2)(b), 6 Dec 1943.

CHAPTER XI

THE ORGANIZATION OF GENERAL AND RELATED HOSPITALS 1942 - 1945

As already noticed (above p. 115), the relations of the general hospitals and of the service command surgeons' offices to higher authority changed simultaneously in the middle of 1942. At that time the surgeons' offices became branches of the supply divisions, while the general hospitals were, with certain exceptions, removed from the jurisdiction of The Surgeon General and placed under the authority of the service commanders.[1]

This settled the position of the service command surgeons' offices and the general hospitals in the War Department structure (at least for the time being), but it did not directly affect their internal arrangements. However, a standard plan for the surgeons' offices was put forward at the end of 1943, as we have seen (above p.136). A similar project was already under way for the hospitals.

Planning a Standard Organization for Hospitals

Late in 1942 the authorities in Washington began to scrutinize the organization of the general hospitals and to work out projects of reform. This envisaged changes in administrative procedures and in the system of personnel allotment, but only the structural and functional aspects of the reorganization will be considered here.

In 1942 the only guides to the ordering of a general hospital were still the technical manual of 16 July 1941 and a few pages in the Military Medical Manual, an unofficial publication of 1940. As new activities were added to the functions of general hospitals, the commanding officers in some cases merely hung them on the old framework with no attempt to work out a logical, efficient plan.[2] In November 1942 the Wadhams Committee cited the case of a general hospital where thirty-three officers in charge of various sections reported directly to the commanding officer. The committee expressed the belief that the organization of larger hospitals could be altered for more efficient and economical operation with resultant savings in medical and administrative manpower, and suggested a model arrangement to achieve that end. This plan provided for a commanding officer's staff to consist of an executive officer, a medical officer of the day, and an administrative officer of the day. The other sections would be grouped in three divisions: (1) a medical division supervised by a chief medical officer, comprising the medical service, surgical service, dental service, nursing service, admission service,

and records; (2) an administrative division headed by a chief administrative officer, comprising the office of adjutant, the supply section, the office of special services, the dietitians department, the office of inspection, and the medical detachment; and (3) a service division under a chief service officer, handling maintenance of buildings and grounds, motor transport, laundry, fire protection, and police protection. A simplified plan of this sort, the committee stated, "would coordinate and expedite the activity of the various departments and would also afford the commanding officer sufficient time to make inspections and develop long-time planning."

The Commanding General, Services of Supply, transmitted this proposal to the Office of The Surgeon General for comment. In reply the latter expressed doubt that thirty-three sections reported directly to the commanding officer in any hospital: they would report to the executive officer; moreover, the "most elaborately organized hospital" had no more than six professional services (medical, surgical, eye-ear-nose-and-throat, neuropsychiatric, x-ray, and laboratory) in addition to the medical detachment, detachment of patients, Army Nurse Corps, civilian personnel, quartermaster's department, and utilities. The latter were under the administrative control of the executive officer and adjutant, only questions of policy reaching the commanding officer. The Surgeon General's Office referred to the manual of 1941 as representing long experience and the opinion of able officers, and concluded that "no advantage would appear to accrue for [from ?] any major change at this time."

The response of Headquarters, Services of Supply, was brief: "The Office of The Surgeon General will take immediate steps to effect [the committee's recommendations] and report thereon by 15 January 1943." The Surgeon General's Office answered on 16 January that it was negotiating with Dr. B. C. MacLean, Superintendent of the Strong Memorial Hospital, Rochester, New York, to make a comprehensive study of military hospital organization and administration. A later report (8 March 1943) stated that Dr. MacLean was unable to accept immediately.[3] In April 1943, however, he was brought into the Office of The Surgeon General and took part in the projected investigation.[4]

Dr. MacLean became a member of the Hospitalization and Evacuation Division with the rank of lieutenant colonel and made a series of field trips to collect material for the study. Then and later in 1943 he was joined by other investigators, some of whom were brought in from the service commands. The study was carried on in collaboration with the Control Division, Surgeon General's Office.[5] Lieutenant Colonel MacLean left the service in September 1944, but the working out of new procedures and organizational plans for Army hospitals continued.

Meanwhile the Control Division, Army Service Forces, had also entered the field. As early as October 1943 survey teams were sent to Camp Blanding (Fla.), Fort Jackson (S. C.), Fort Sill (Okla.), Camp Hood (Tex.), and Fort Lewis (Wash.) for the purpose of collecting information on the operation of field installations, including hospitals. At first The Surgeon General's Office and Army Service Forces operated separately in the matter. Later, however, they combined forces, and the new technical manual on hospital administration which ultimately appeared was a joint product.[6]

In the course of the study, organizational charts of various hospitals were collected and subjected to scrutiny. A message from the Office of The Surgeon General to the Fourth Service Command on 2 March 1944 indicated the trend of thought at Washington. It was critical of the general hospital charts of that command as showing an "unwarranted number" of independent services directly responsible to the commanding officer, and expressed the opinion that, in line with Army Service Forces policy, the number of separate services should not exceed four or five. The communication also mentioned that an organizational chart for general hospitals was under study with a view to issuing it as a directive.[7] Such a chart was actually approved but not published.[8]

While the organization of general and station hospitals was being considered, the scope of the planning operation was broadened to include the new regional and convalescent hospitals, created during the first half of 1944, and the new hospital centers that followed a year later.[9]

Early in 1945 at a conference of service command surgeons the subject of standard hospital procedure and organization was discussed.[10] About the same time, in February, the first fruits of the hospital inquiry appeared when the War Department began the issuance (in parts) of a new technical manual, "Administration of Fixed Hospitals, Zone of Interior" (TM 8-262). The purpose of issuing the manual piecemeal was to enable the sections to be tested individually in the field and to facilitate their adoption by overworked hospitals.[11] The manual had been approved by the Army Air Forces, which worked out the plan of Aviation and Medical Service in the section on regional hospitals.[12]

The New Plan for General Hospitals

Chapter I on "Hospital Organizations" (TM 8-262) was dated 1 July 1945, some two months after V-E day. The first section dealt with "Standard Functional Organization of Named General Hospitals." It provided charts and descriptive material on the functional aspects of hospital organization. The administrative side was treated more fully than the profes-

sional, since the latter was "subject to constant variation by reason of changes in types of patients." To economize on personnel, the functions of more than one division might be performed by one person, or if the duties of a single division were too onerous a second in command, or deputy, might be appointed, but the standard plan was to be adhered to:

> While hospitals vary as to the type of specialized medical treatment offered, their primary mission and general functions are the same. The adoption of a standard organization will result in improved operation, make possible more effective utilization of personnel, and permit simplification of procedure. Deviations from this standard organization will not be permitted unless prior authorization is granted individual installations by the Service Commander having jurisdiction.[13]

The new manual was thus more exacting in its requirements than the previous one had been.[14] The organization it prescribed was also more elaborate, as its chart indicates (see Chart XXV).[15] The hospital organization was still divided into three parts: (1) the group of functionaries in or immediately connected with the office of the commanding officer (formerly called the "unit staff"), (2) the administrative staff divisions, and (3) the professional staff divisions. But the make-up and functions of these parts had been considerably altered.

(1) The commanding officer himself, in addition to his usual responsibilities, had one not previously mentioned: he was to coordinate the hospital administration with outside activities such as the American Red Cross, United States Employment Service, Veterans Administration, United States Civil Service Commission, and Selective Service. He also had two new assistants in direct relationship with himself: the control officer and the public relations officer. In addition, the medical inspector (formerly the hospital inspector) had been moved up from the administrative service. Among his duties were now mentioned, specifically, oversight of sanitation, venereal disease control, inspection of training, discipline and morale, and investigation of complaints of the hospital complement and patients.[16] On the other hand, the adjutant, chaplain, medical supply officer, and personnel officer were relegated to the administrative staff level, the chaplains' office becoming a branch of the personnel division.[17]

(2) The administrative divisions increased from eight to eleven. Wholly new agencies in this echelon were the judge advocate's division, the fiscal division, and the security and intelligence division. If no judge advocate was assigned to the command a legal assistance officer was to take his place for

STANDARD ORGANIZATION CHART FOR NAMED GENERAL HOSPITALS

CHART XXV

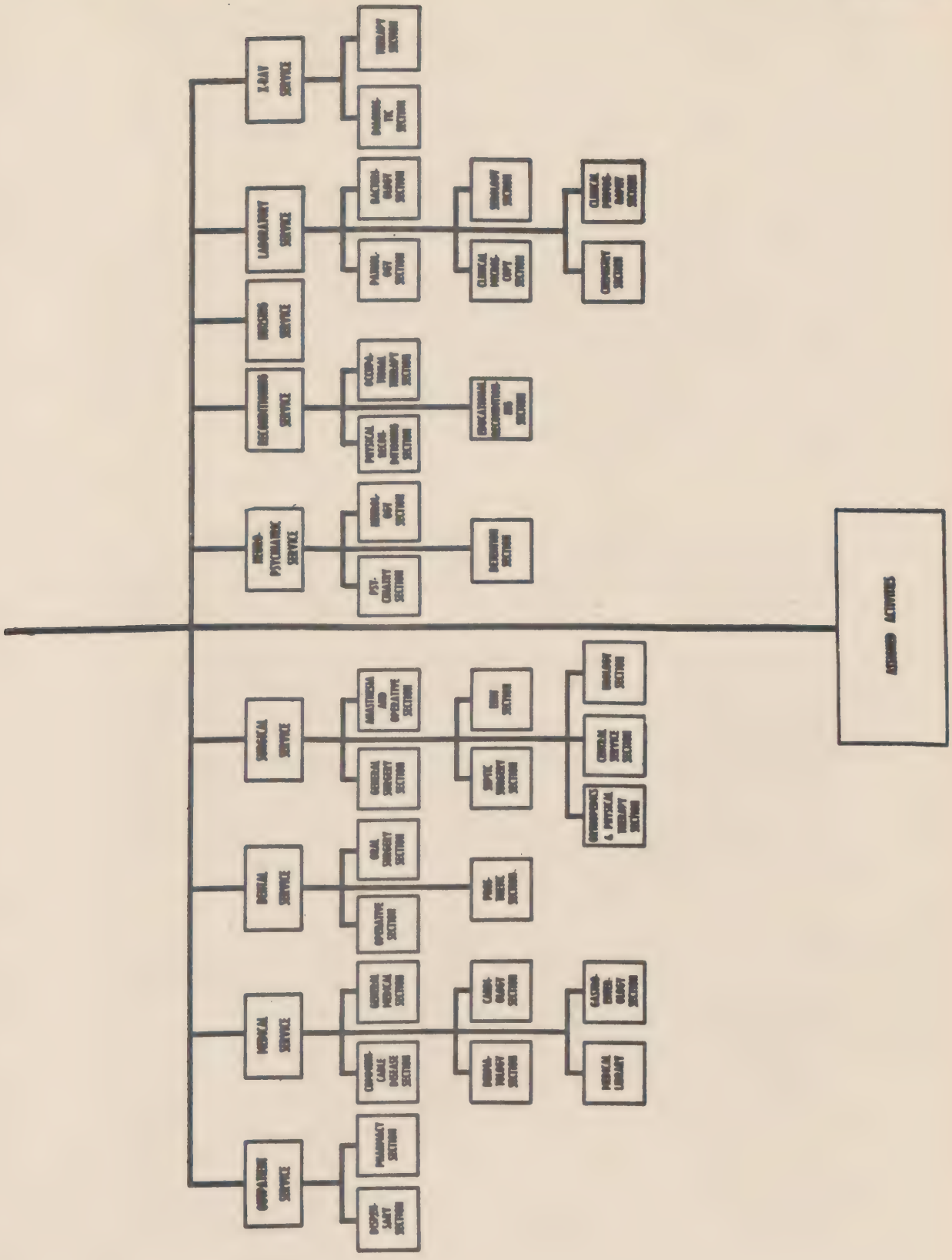


CHART XXV 1.3

legal counseling service, the judge advocate stationed in the area performing the other functions of the office. The fiscal division absorbed the financial duties of the personnel officer and adjutant. The functions of the old utilities officer were taken over by a branch of the engineer division. The principal chief nurse was no longer a member of the administrative staff; instead, a nursing service was added to the professional staff.

(3) The professional divisions now numbered nine instead of six. Here the new element (aside from nursing) was the reconditioning service; the neuropsychiatric branch of the medical service was merely raised to division level. The medical service still had six sections, but a medical library and a dermatology section replaced the neuropsychiatry and officers sections. The surgical sections increased from four to seven, the new sections being anesthesia and operative, septic surgery, and central service. (The central service section was responsible for the sterilization of surgical equipment and materials and maintained a supply of such items in condition for immediate use.)

To complete this summary view, the block on the organization chart labelled "assigned activities" included T/O units, Prisoner of War Camps, and other organizations or activities assigned to the command.[18]

It will be observed that earlier opinions as to the practicability of greatly reducing the number of services directly responsible to the commanding officer were not confirmed by the new manual. The Wadhams Committee had recommended only three such divisions in addition to the commanding officer's three-man personal staff. The Office of The Surgeon General as late as March 1944 had suggested only four or five. The manual, on the other hand, provided for at least twenty services and divisions reporting to the commanding officer, with the possibility of adding more if the necessity arose.

What effect the new manual had on actual practice may be judged by comparing the organization of a number of general hospitals before it appeared with that which obtained afterward. For this purpose the annual reports of the following hospitals for 1944 and 1945 have been consulted: Ashford, W. Va.; Baxter, Wash.; Beaumont, Tex.; Birmingham, Calif.; Dibble, Calif.; Fletcher, O.; Harmon, Tex.; Hoff, Calif.; Kennedy, Tenn.; Lovell, Mass.; Mason, N.Y.; Tilton, N.J.; Vaughan, Ill.; and Wakeman, Ind.[19]

In some respects these hospitals anticipated the organization prescribed by the manual. This was due in part to the fact that they were trying to conform as far as possible to the section of Army Service Forces Organization Manual M-301

for 15 December 1943 dealing with post organization, some features of which resembled the later TM 8-262 (see Chart XXIII). In fact several hospitals stated specifically that such was the case. The conformity is particularly noticeable in the group of agencies most closely connected with the commanding officer --what was formerly called the "unit staff". In the TM 8-262 this group included the medical inspector, control officer, and public relations officer. In the hospitals others might be added, such as the adjutant (at Kennedy and Vaughan), the reconditioning service, chaplain, and field training unit (at Harmon), or post funds (at Baxter). On the other hand, at Tilton the public relations officer and hospital inspector were on the "administrative" level. At Kennedy the medical inspector was similarly placed and no control officer was indicated. All the above applies to conditions at the end of 1944. A year later, after the appearance of the TM 8-262, the situation in the commanding officer's group seems to have remained about the same. At Ashford, however, a director of supply had been added with staff supervision over the quartermaster and medical supply.

The group of "administrative" agencies in 1944 showed less uniformity among the several hospitals. They also showed less tendency than the staff group to anticipate TM 8-262, partly because M-301 had less similarity to the later manual in this respect. Following M-301, Dibble and Birmingham divided their administrative structure into two parts--"major" or "operational" divisions, and technical divisions. It was a common practice to have the chemical warfare, ordnance, quartermaster, transportation, and signal services set up as separate divisions, the system adopted in M-301. Frequently there was also a medical supply division separate from the rest of supply. Tilton, however, had already begun to consolidate its supply divisions. At Mason and Fletcher, hospital administrative services were set off from post administrative services. Fletcher, in fact, had a unique organization, at least on its chart--a combination of post and hospital structure in which "the general hospital is considered a unit present on the post and directly responsible to the Commanding Officer of the Post." Wakeman pointed out that as the hospital was on an established post, the latter provided fiscal, transportation, ordnance, laundry, and bakery facilities. The number of administrative divisions varied considerably, from half a dozen at Tilton and Hoff to twenty-six at Fletcher, with an average of about fifteen for the group. Vaughan had ten divisions, which were rather similar to those specified in the later manual.

By the end of 1945 the administrative services in some of the hospitals showed changes, certain of which brought them more into alignment with TM 8-262. Dibble was now very close to the new manual. At Dibble and Harmon a number of services had been consolidated under supply. On the other hand, at Birmingham, Fletcher, Baxter, and Mason the supply services remained dispersed. At Tilton a new personal service division

had been set up to include public relations, information and education, Red Cross, special services, personal affairs, AAF hospital liaison officer, AGF personal affairs, service libraries, savings promotion, insurance, legal assistance, claims, and other War Department and civilian agencies. A similar division was initiated at Fletcher and Kennedy. It will be noticed, however, that no such division occurs in TM 8-262. Moreover, the number of administrative services in the whole group of hospitals did not decrease, remaining at an average of fifteen compared with the manual's eleven or twelve.

In 1944 the arrangement of the professional services varied somewhat from one hospital to another. As TM 8-262 allowed for this divergence the appearance of the manual apparently did not affect the situation to any significant extent. Some changes, however, did occur between 1944 and the end of 1945. At Baxter, for example, the reconditioning service, which had been separate from the professional divisions, was combined with them. At Tilton the Station Surgeon, formerly a member of the administrative staff, was transferred to the professional services. While there were a few small increases or decreases in the number of professional services at particular hospitals the average number remained in the neighborhood of nine, which was that suggested by TM 8-262.

On the whole the structure of general hospitals seems to have been less affected by the new manual than might have been expected. Certainly there was no attempt to follow the model line for line. At the same time the trunk and major branches were similar in most cases, even if the twigs did not everywhere sprout in exactly the same way. This degree of similarity to the approved pattern and partial uniformity among the various specimens had largely been attained, however, before the issuance of the new manual, as we have seen.

The New Plan for Regional Hospitals

A new type of installation having some of the functions of general hospitals was the regional hospital, established early in 1944. As we have seen (above p. 145) its organization became a subject of study along with that of other hospitals. As a result a standard plan for the new institution was published in TM 8-262. Before describing this plan, however, the earlier history of regional hospital organization needs to be sketched.

Regional hospitals as authorized in April 1944, were the responsibility of either the Commanding General, Army Service Forces, or the Commanding General, Army Air Forces. These commanders were permitted to place them "under the direct jurisdiction of the commanding generals of service commands or of Army Air Forces Commands or air forces respectively, when such

action is deemed to be in the interest of efficient use of such hospitals".[20] The regional hospitals, however, were station hospitals redesignated, with their ambit broadened, and had therefore been under the control of post commanders. In a speech before a Service Command Conference in July 1944 The Surgeon General stated that they should remain so. But to save time and energy "all administrative details which relate solely to the technical and routine administration of patients . . . should be delegated specifically to the hospital commander."[21] In his speech closing the same conference, the Commanding General, Army Service Forces, said he would leave it to the service commanders whether regional hospitals were to be directly under service command jurisdiction or under post headquarters, but he seconded The Surgeon General's views as to freedom of action for the hospital commander: "The post headquarters as a rule would add little or nothing to most of the papers that go through, and certainly the post commander shouldn't try to be the post doctor." He summarized the purpose of the new hospitals as

> first, to free the general hospitals in the United States as much as possible for the treatment of patients returning from overseas and those that are desperately ill. Second, to treat patients from the zone of the interior who would normally have gone into a general hospital in a regional hospital, with the exception of those who must be treated in a specialized general hospital. Third, to use the regional hospitals to serve the region in place of general hospitals, but also to economize on medical personnel and facilities as the military population of the United States declines by serving the region within a radius of 25 [75 ?] miles of the hospital.[22]

A year after this meeting, in July 1945, the section of TM 8-262 dealing with regional hospitals appeared simultaneously with that on general hospitals. The standard organization it prescribed was designed, with certain modifications, for either regional or "station medical services", as the manual called them. If the regional hospital was not located on a post but constituted a post in itself, the organization was to be the same as that of a general hospital. On a post it differed functionally from a station hospital in four ways: (1) the adjutant, when authorized by the service commander, could issue directives changing the status of patients, whereas a station hospital's directives affected only hospital policy; (2) the regional hospital's orthopedic section included a brace shop, the station hospital's did not; (3) the station hospital operated no occupational therapy section, and (4) no aviation medical service.[23]

The new plan for a regional hospital located on a post differed from that for a general hospital mostly on the administrative side. In the case of the regional hospital the administrative service was comparatively simple, since the various agencies required by a post were eliminated; namely, the judge advocate, fiscal division, personnel division, engineer, security and intelligence division, control officer, public relations officer, and all of supply except the medical section which was retained by the hospital. The plan of professional services for regional (station) hospitals was practically identical with that for general hospitals, except that in the former psychiatry was not a separate service but a branch of medical service.

What effect did this new model have on the actual arrangements of regional hospitals? Examination of the annual reports of nineteen such hospitals for 1945 fails to disclose any specific reference to compliance with the standard chart. In fact TM 8-262 was mentioned only once, and then solely as governing procedure for the admission of patients.[24] One hospital reported its organization to be "similar to that of a general hospital as outlined in TM 8-260"--the manual of 1941.[25] A number of others seemed to be following the same plan.[26] Certain hospitals made changes in their organization during 1945, but these changes apparently had nothing to do with the new manual. Thus the Waltham Regional Hospital reconstituted its laboratory and X-ray sections as independent services (in agreement with TM 8-262), but the reason given was "increased activity".[27] On the other hand, the Fort Benning Regional Hospital converted the neuropsychiatric section of its medical service into a separate service--the precise opposite of the shift indicated in the hospital manual.[28] If these examples can be taken as representative of the general practice, it must be concluded that the organizational plan of the new manual had made no particular headway in regional hospitals, at any rate by the end of 1945.

Hospital Centers

Shortly before the end of the war certain of the general hospitals were embodied in hospital centers, which became an important element of Medical Department activity within the service commands. The concept had been mentioned in the War Department manual on fixed hospitals (TM 8-260) as early as 1941:

> When possible two or more general hospitals with a convalescent camp (capacity of 1,000) are grouped together under an overhead known as the hospital center. This arrangement has the advantage of economy of administration, and offers the opportunity of specialization and pooling of transportation facilities. From an administrative point

> of view it is highly desirable to pool or otherwise centralize such features as quartermaster and medical supplies, laundries, bakeries, water transportation, power, heat, military police and fire prevention. Professionally, the hospital center is advantageous in that it permits the special assignment of one general hospital to any desired specialty or group of cases.[29]

General hospitals were of course an old institution. The convalescent hospitals operating in the Zone of the Interior, however, came into being only in 1944.[30] At that time the patient load required either the construction of new general hospitals, the conversion of station hospitals into general hospitals, or the removal of convalescents from general hospitals to some other type of installation. New general hospitals, it was felt, would be an unwarranted expense, while the conversion of station hospitals was impracticable due to insufficiency of specialists. The only alternative therefore was to establish convalescent hospitals,[31] either by redesignating station hospitals or by creating new installations.[32]

Accordingly a War Department circular of 11 April 1944, "in order to hasten the recovery of convalescents," required the operation of a convalescent section in each hospital

> wherein patients may be reconditioned, who no longer require daily medical and nursing care, but who are not sufficiently recovered to return to duty. Separate zone of interior convalescent hospitals primarily for the reconditioning and rehabilitation of war casualties may be established. . . . The Commanding Generals, Army Air Forces and Army Service Forces are authorized to place . . . convalescent hospitals (ZI) under the direct jurisdiction of commanding generals of service commands or of Army Air Forces commands or air forces, respectively, when such action is deemed to be in the interest of efficient use of such hospitals.[33]

During the following months of 1944 lists of Service Forces and Air Forces convalescent hospitals were designated by the War Department, and in August seven general hospitals were renamed "general and convalescent" hospitals.[34]

The new convalescent program was outlined in a letter from the Office of The Surgeon General to service command headquarters on 4 August 1944. This was amplified and revised by an Army Service Forces circular in the following December.[35] The latter contained detailed organization charts of a convalescent hospital as a separate installation without indicating what would be the structure of a general convalescent hospital.

Judging from the annual reports for 1944 of four of the seven general convalescent hospitals, the new aspect of their activity occasioned little basic change in the hospital structure. A convalescent unit was already in operation at Brooke General Hospital before the issuance of the new directives. Neither there nor at Wakeman General Hospital were separate administrative services allocated to the convalescent units. At England and Percy Jones General Hospitals the case was somewhat different. Percy Jones consisted of three separate plants: the main hospital, the annex, and the convalescent facility. Each of these had an assistant executive officer, and most of the administrative departments operated sub-departments at the facility and the annex. A chart of the hospital about this time shows an administrative staff for the convalescent facility of an assistant mess officer, an assistant supply officer, an assistant personnel officer, and an assistant registrar. At England the convalescent facility was joined with the hospital reconditioning section to form the reconditioning service, which had its own administrative group. This included a plans and training officer, a physical record officer, an inspector, guard and billeting officer, a supply officer, and a mess officer.[36]

By the end of 1944, therefore, convalescent hospitals as separate institutions and general hospitals with convalescent facilities attached had become regular parts of the hospital system in the zone of the interior. It remained to combine these two elements--the result being the hospital center. The occasion for the combination was the great influx of patients from overseas at the beginning of 1945. This necessitated the creation of convalescent accomodations on a scale not hitherto required.

The program of expansion was hastened by a letter from President Roosevelt to the Secretary of War (4 December 1944). In it the President expressed himself as

> deeply concerned over the physical and emotional condition of disabled men returning from the war. I feel, as I know you do, that the ultimate ought to be done for them to return them as useful citizens--useful not only to themselves but to the community.
>
> I wish you would issue instructions to the effect that it should be the responsibility of the military authorities to insure that no overseas casualty is discharged from the armed forces until he has received the maximum benefits of hospitalization, vocational guidance, pre-vocational training, and resocialization.[37]

The new situation was different from that which had earlier resulted in the attachment of convalescent facilities to general hospitals. Those facilities had been established to provide for the overflow of partially recovered patients from within the hospital itself. Now certain of the hospitals were receiving in addition many patients from overseas and elsewhere who might need no general hospital care but whom it was desirable to keep within reach of the specialists of general hospitals. Two problems confronted the hospitals: how to secure additional accomodations for convalescents and how to administer the enlarged plant with greater efficiency and economy of manpower. The problem of accomodation was solved by taking over and converting some of the now empty barracks at training camps where, or near which, hospitals were located.[38]

The problem of administration was more complex. It was tackled on the spot at Percy Jones Hospital by the Office of The Surgeon General. One of the chief difficulties proved to be the handling of patients' records in such a way as to permit a smooth flow of patients within the installation, unhampered by delays and errors in admissions, transfers, and dispositions. Representatives of The Surgeon General's Office[39] visited the hospital in March 1945 and in cooperation with the service command and hospital authorities worked out a new plan of organization.[40] It involved the creation of a "hospital center" and waited only on the issuance of proper authority to be put in operation.

This was obtained early in April 1945. The first move in that direction was a War Department circular (4 April 1945) authorizing the establishment of hospital centers in the zone of the interior. Such a center was to be

> composed of center headquarters, two or more general hospitals, two or more convalescent hospitals or a combination of general and convalescent hospitals with such additional medical installations at the same station, such as regional and station hospitals, infirmaries, dispensaries, laboratories, dental clinics, etc., as may be collectively administered under the center headquarters. Hospital centers (Z1) will be established only in localities having multiple medical installations in close proximity to each other. . . In order to conserve personnel and facilities common administrative functions will be combined to maximum extent possible. Receiving, evacuation, medical supply, general supply, sanitation, transportation, laboratories, registrar, hospital fund, finance, and postal service are among the common activities that may be centralized.[41]

A second War Department circular, dated seven days later (11 April 1945), established nine hospital centers, each consisting of one general and one convalescent hospital, under control of the service commands.[42] This was followed shortly afterward (16 April 1945) by an Army Service Forces circular which amplified the recent instructions. It stated that where a hospital center was located on a post (Class I or II installation) the post commander would furnish to the center such post administrative and overhead services as were common to all Army Service Forces activities on the post, but that the hospital center commander would report directly to the service commander for the operation and technical administration of the center. The circular included a "suggested standard organization chart which is furnished as a guide for the establishment of a hospital center" (see Chart XXVI).[43]

This chart was by no means the final word on hospital-center organization so far as the Office of The Surgeon General was concerned. Three months later, in early July 1945, the Chief of the Operations Service, SGO, addressed a letter to the commanding generals of service commands where hospital centers were located. He referred to the "established policy of this office that a basic standard administrative structure is a prerequisite to standardized administrative procedures" and submitted charts of the Percy Jones Hospital Center, "the result of considerable study" by the service command, and hospital authorities, and the Office of The Surgeon General. Comments on the charts by the service commanders were requested and, if the latter so desired, by their control divisions and the local hospital centers. (For the main Percy Jones chart as modified in certain particulars, see Chart XXVII).[44]

The reaction to the Percy Jones plan was somewhat varied. Several commentators believed the organization to be basically sound. But there were a number of criticisms. The authorities of the Fourth Service Command suggested more than one headquarters commandant, more than one mess department, and two patients detachments coordinated by the registrar. The Ninth Service Command, on the other hand, believed that some consolidation was desirable to reduce the number of staff officers reporting to the center commander: for instance, all technical service might be concentrated under supply. The Fifth Service Command's opinion ran along similar lines; the commander of Wakeman Hospital Center remarked that the Percy Jones organization was "somewhat centralized in its character." At Wakeman, he pointed out, the headquarters staff of the center was "primarily the eyes and ears of the commanding officer." Its function was not mainly operating but advisory and corrective. Moreover, the number of units responsible to a supervisor was kept sufficiently small to permit effective coordi-

nation. "It is my opinion," wrote the Wakeman commander, "that decentralization rather than centralization should be the basis of good staff organization and an efficient operating structure for a Hospital Center." The Surgeon of the Fifth Service Command stated that the Wakeman Center had at first been organized in a manner similar to that of Percy Jones, but that the system did not function well and had therefore been decentralized as the result of study by the control division and the surgeon's office.[45] The authorities at Percy Jones, however, held to their own theory: "There are many advocates of decentralization, but it was felt by the Commanding General [of the center] that to carry out the thought behind the establishment of a Hospital Center, the only course was centralization in all departments."[46] At the same time only a small number of staff officers reported directly to the commanding general; the rest reported in matters of routine to his executive officer.[47]

Criticism of the Percy Jones plan reflected, to some extent, the fact that requirements varied from one center to another. This was particularly true where a center was located on a post, as several commentators pointed out.[48] The Percy Jones Center constituted a post in itself.

With the operating experience of the new hospital centers to draw upon, the Office of The Surgeon General proceeded to formulate, for inclusion in TM 8-262, a standard plan of hospital center organization. It was designed for centers "which in themselves constitute a military installation."[49] For the chart of the headquarters staff and central services see Chart XXVIII.

The general plan and statement of functions of the entire center were similar in many respects to those of a general hospital as described in TM 8-262. This was true of both the administrative and professional sides of the organization. There were, however, a number of differences. Thus, the center had three commanding officers instead of one--a commander of the center and his subordinates, the commanders of the general hospital and the convalescent hospital. The center commander, in addition to the functions ascribed to the head of a general hospital in TM 8-262, was "responsible for carrying out the mission of the Hospital Center (ZI) and the centralization and coordination of the functions of its components." The commander of the convalescent hospital

> a. Is directly responsible to the commanding officer of the Hospital Center (ZI) for the proper performance of the assigned mission of the Convalescent Hospital and exercises all command functions relevant to its operation.

b. Establishes policies for, and coordinates and directs the activities and services rendered by divisions and services of the Convalescent Hospital to assure that all patients obtain maximum hospitalization benefits.[50]

The functions of the general hospital commander were substantially the same.[51]

Other innovations in the administrative staff were introduced. Three new officers were added to the top echelon--a director of professional services, a director of dental service, and a director of nursing service, with the following duties:

Director of Professional Services

a. Acts as advisor to the Commanding Officer of the Hospital Center (ZI) on all professional matters.

b. Is responsible for directing and establishing policies and procedures governing the operations of the respective professional services functioning at both the General Hospital and the Convalescent Hospital.

c. Assures that all directives, regulations, orders, bulletins, etc., affecting operation of the professional services are complied with throughout the Hospital Center (ZI).

d. Senior medical officer on duty with professional services at the Hospital Center (ZI) ordinarily acts as Director of Professional Services in addition to his other duties.

Director of Dental Service

a. Advises the Commanding Officer of the Hospital Center (ZI) through the Director of Professional Services, on all dental matters.

b. Is responsible for the dental service program for all military personnel within the Hospital Center (ZI).

c. Coordinates use of dental facilities and utilization of dental personnel.

d. Is responsible for the preparation of necessary dental statistical data.

e. Senior dental officer on duty at the Hospital Center (ZI) ordinarily acts as Director of

Dental Service in addition to his other duties.

Director of Nursing Service

a. Advises the Commanding Officer of the Hospital Center (ZI), through the Director of Professional Services, on all matters pertaining to the Nursing Service.

b. Supervises and coordinates the operation of the Nursing Service at the General Hospital and at the Convalescent Hospital.

c. Senior nurse on duty at the Hospital Center (ZI), ordinarily acts as Director of Nursing Service in addition to her other duties.

It appears from these statements that the directors of the dental and nursing services were intended to be subordinate to the director of professional services, at least where matters of policy were concerned, although the chart gives all three services an equal footing.

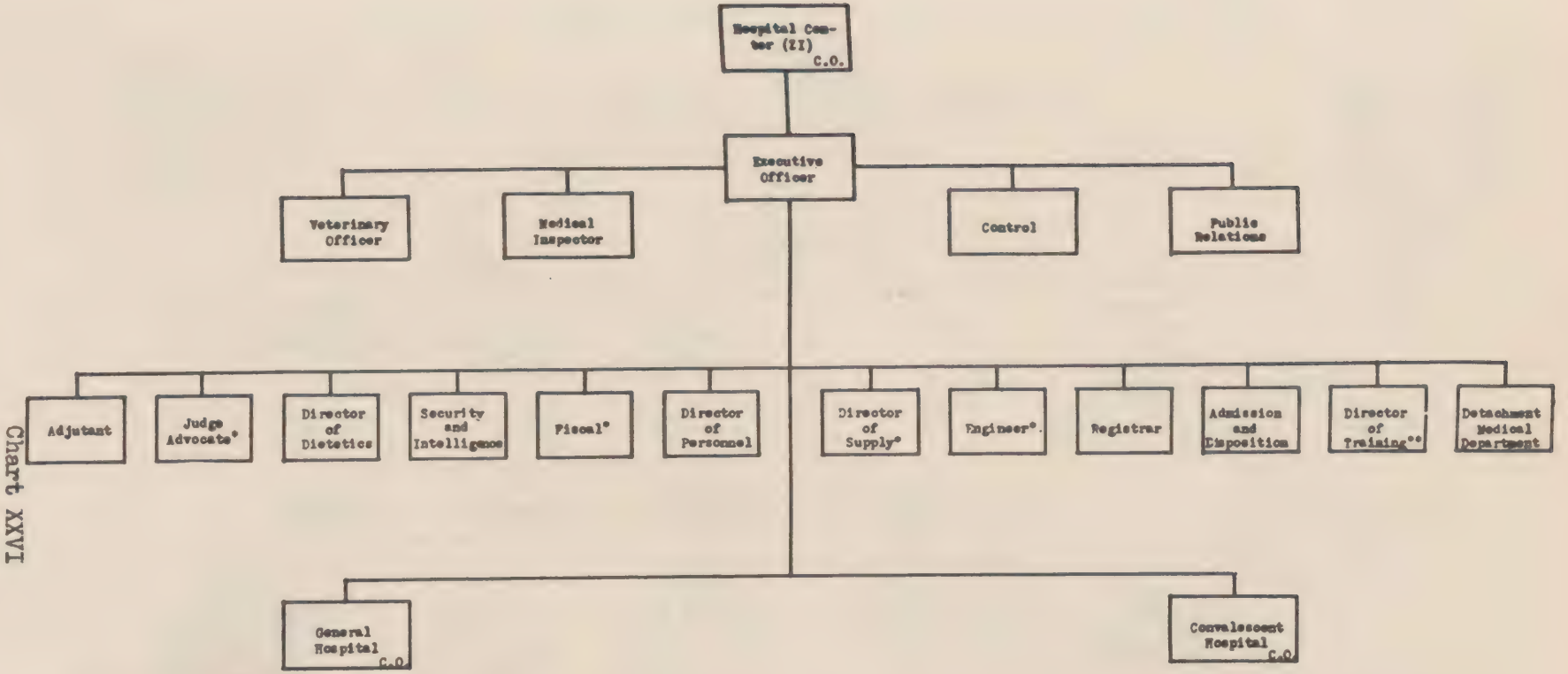
The reconditioning council, an instrumentality of the director of professional services

a. Advises the Commanding Officer of the Hospital Center (ZI), through the Director of Professional Services, on all matters pertaining to the reconditioning program in both the General and Convalescent Hospitals.

b. Formulates policies to be followed in the reconditioning programs in the General and Convalescent Hospitals.[52]

The staff members of the second administrative echelon of the hospital center were the same in name and number as those of the general hospital described in TM 8-262. But there were some differences in components and duties. Thus the registrar's office had a new functionary, the custodian of patients' funds, who "acts as custodian of patients' funds and valuables" and "makes proper disposition of money, valuables, and other personal effects of deceased and insane patients." The admissions and dispositions branch of the registrar's office, instead of examining patients prior to admission and assigning them to the proper wards, "examines patients referred to the General Hospital," and "assigns patients to the proper wards or refers them to the Convalescent Hospital in appropriate cases." This branch also "checks all patients arriving at or departing from the General Hospital on admission, discharge, pass, leave or furlough."[53]

Chart XXVI



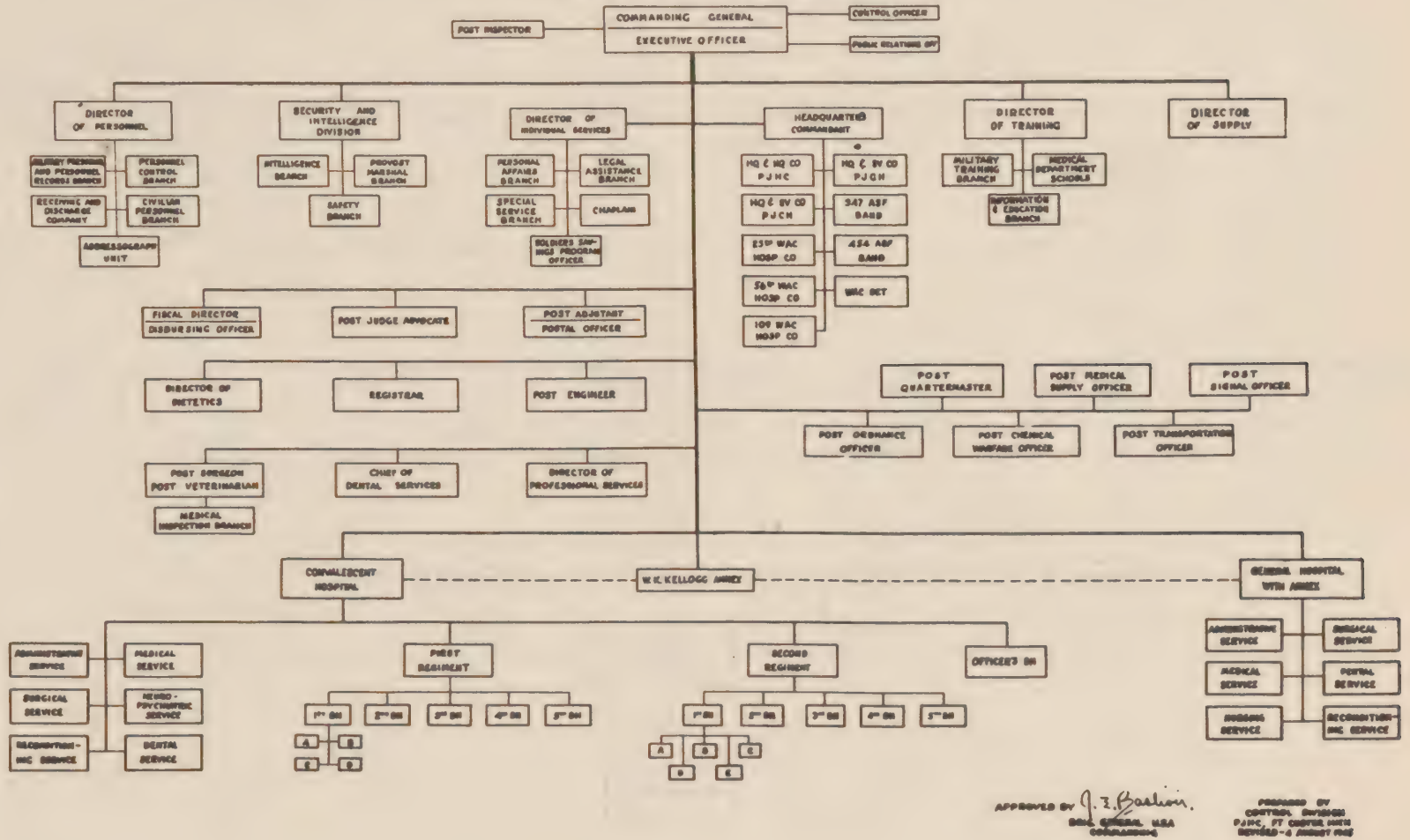
* Where hospital centers are located at Class I or Class II Installations, the post commander will furnish post administrative and overhead services common to all ASF activities located thereat in order to prevent duplication of effort and personnel.

** For duty personnel.

Inclosure to ASF Circular No. 135, 1945

ORGANIZATIONAL CHART OF PERCY JONES HOSPITAL CENTER

FORT CUSTER, MICHIGAN



APPROVED BY J. Z. Bartlein
BRIG. GENERAL, U.S.A.
COMMANDING

PREPARED BY
CONTROL DIVISION
PJHC, FT CUSTER, MICH
REVISED - 6 AUGUST 1945

Chart XXVII

STANDARD ORGANIZATION OF A HOSPITAL CENTER (ZI)

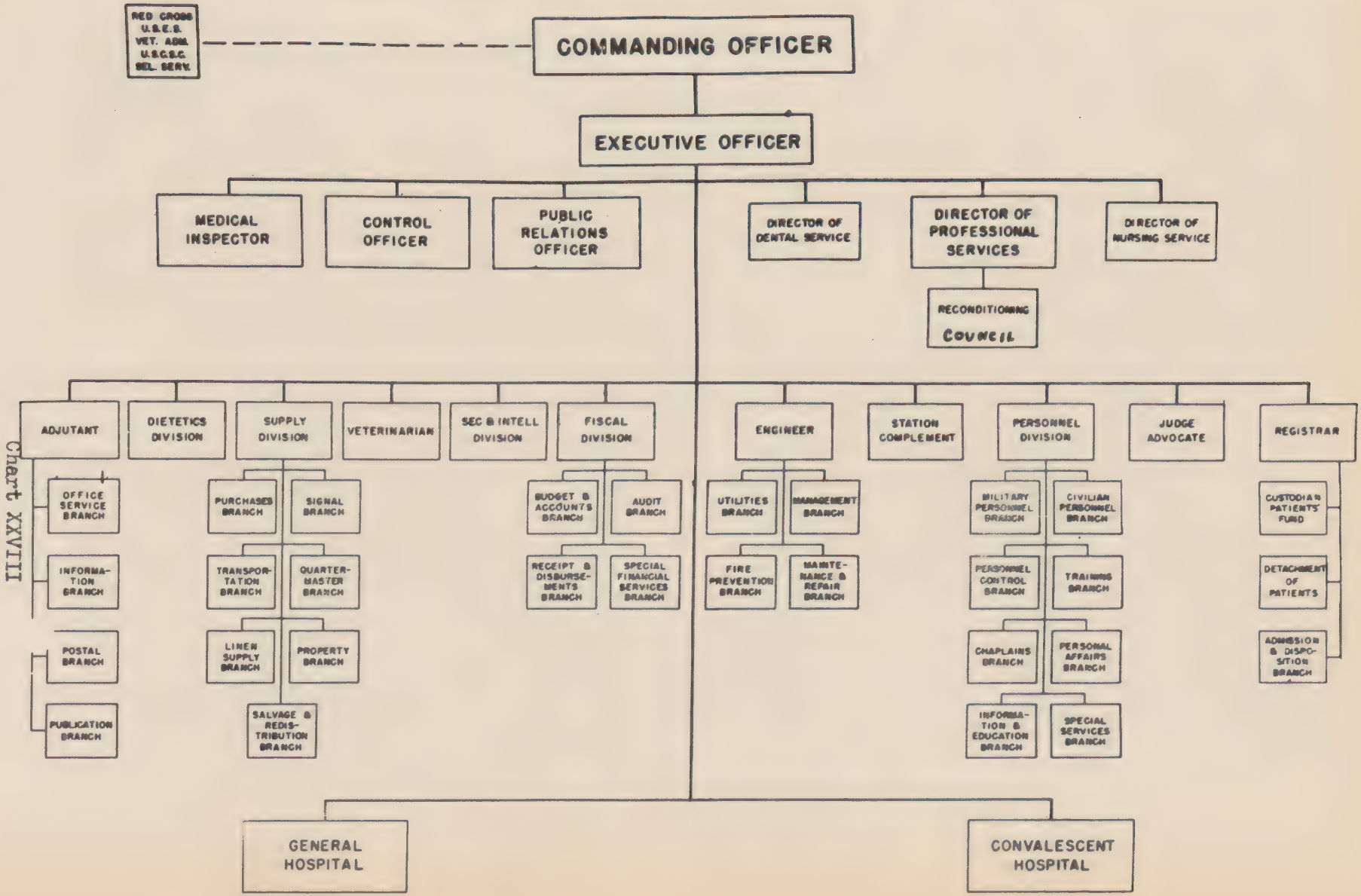


Chart XXVIII

The Adjutant of the center, unlike his opposite number of the general hospital in TM 8-262, "commands the band." His office service branch provided "stenographic service for disposition and other boards" but its duties did not include furnishing ration service for the complement personnel. His information branch (new) "operates the Hospital Center (ZI) information service" and "maintains the Hospital Center (ZI) locator files." Operating the postal locator service is not mentioned among the duties of the postal branch.[54]

In the personnel division, the authorization officer of the general hospital (TM 8-262) became the personnel control branch of the center, with identical duties.[55]

As to the fiscal division, the difference here was that the audit branch did not have among its stated functions the duty of insuring the "audits are adequate in order to detect irregularities," etc., although the omission perhaps had no sinister significance.[56]

The dietetics division, as its new function, "details officers of the division to duty with the General Hospital and the Convalescent Hospital to act as liaison officers between this Division and the component hospitals."[57]

Finally a linen exchange branch was added to the supply division. This branch

> (1) Provides for the receipt, storage and issue of linens, towels, and hospital clothing for patients in the General and Convalescent Hospitals.
>
> (2) Arranges for the laundering and minor repairs of linen supplies used by the command.
>
> (3) Segregates and makes proper disposition of worn-out linen supplies.[58]

In the standard plan the administrative side of the center included, besides the headquarters echelons just dealt with, certain agencies in the constituent hospitals. The commanding officers of these hospitals and their duties have already been mentioned. Each had an administrative assistant who

> assists the Commanding Officer, as directed, in the performance of his duties. . .
>
> Provides mail, messenger, files, stenographic, and other miscellaneous service for the General (Convalescent) Hospital.
>
> Acts as liaison officer to the Executive Officer of the Hospital Center (ZI).

Their duties were differently stated on only one point; the administrative assistant of the General Hospital "acts directly, in accordance with policies established by the Commanding Officer, on matters not requiring the personal attention of the Commanding Officer," while the administrative assistant of the convalescent hospital "supervises the work of the staff and coordinates matters of concern or interest to more than one operating division."[59]

On the level which would correspond to the professional services of the general hospital, the convalescent hospital in the standard plan had several branches whose duties were largely administrative in character; namely, the "receiving and disposition service" and the "convalescent regiments." Their functions were stated as follows:

Receiving and Disposition Service

a. Receiving Company

(1) Receives patients assigned to the Convalescent Hospital by the Admission and Disposition Branch or admitted directly from other hospitals.

(2) Insures that preliminary medical examinations is given to all patients upon reception, prepares necessary admission records.

(3) Conducts initial orientation program for all patients.

(4) Insures that all patients are equipped with required authorized clothing, and issues such articles as are lacking.

(5) Recommends convalescent furloughs or sick leaves for personnel in Receiving Company, when appropriate.

(6) Checks all patients arriving at, or departing from the convalescent hospital on admission, discharge, pass, furlough and leave.

(7) Accomplishes assignment of all patients to Convalescent Regiments. Insures that enlisted patients suffering from neuropsychiatric disorders are assigned to the First Convalescent Regiment; enlisted patients suffering from general medical disorders are assigned to the Second; and enlisted patients suffering

from general surgical disorders are assigned to the Third. In case of officer patients, to Officer Patients Company. (The senior psychiatrist on duty acts as Commanding Officer of the First Convalescent Regiment. The Chief of Medical Service acts as Commanding Officer of the Second Convalescent Regiment. The Chief of Surgical Service acts as Commanding Officer of the Third Convalescent Regiment.)

(8) Provides for proper housing, feeding, treating, and other care for convalescent patients during residence in the Receiving Company.

b. Disposition Company

(1) Accomplishes receiving and billeting of patients prior to return to duty, separation from the service, or release from active duty.

(2) Arranges special departure ceremony for patients physically unfit for further active duty.

Convalescent Regiments ...

a. Insure, through battalion and company officers, that patients attend all scheduled formations, classes, and other required activities, such as consultations and examinations. Supervise, through the company officers, the manner in which patients participate in activities which the entire company attends as a unit.

b. Enforce, through the company officers, observation of all limitations and restrictions imposed on the patients' activities by the regimental medical officers, and execution of all special exercises and other activities prescribed by the medical officers.

c. Company officers will recommend passes, furloughs, and leaves for patients assigned to their respective companies.

d. Company commanders will prepare morning reports for the Convalescent Companies

and Officer Patients' Company daily for forwarding to higher echelon.[60]

The professional staff functions as stated in the standard plan for hospital centers differed in only one or two particulars from those assigned to the professional staff of general hospitals in TM 8-262. The reconditioning service, however, was transferred from the general to the convalescent hospital and its functions were restated: the service

a. Operates physical reconditioning, educational reconditioning, occupational therapy, and classification and counseling sections.

b. Supervises and schedules the use of all facilities of the service; schedules all recreation activities during duty hours, and supervises the operation of gymnasia and swimming pools.

c. Maintains all records, charts, and statistical data of the service; advises and assists staff and professional officers in the preparation of master and detailed schedules.[61]

The plan for hospital centers, just described, was ready for publication early in 1946. A suggestion was made that the plan (together with one for separate convalescent hospitals [see Chart XXIX], also completed at this time)[62] should be printed and added to TM 8-262 "in order that the manual will be available as a complete unit for training and future mobilization planning," despite "the contemplated discontinuance of convalescent hospitals and hospital centers (ZI) during the postwar period."[63] The suggestion was not approved and the sections remained unpublished; that on hospital centers, therefore, has been given in more than usual detail here.[64]

The plan for a hospital center as finally evolved by the Office of The Surgeon General differed in some respects from the scheme which it had been mainly responsible for establishing at the Percy Jones Center and which continued to govern that center. In the standard plan a somewhat smaller number of divisions than at Percy Jones (eighteen as against twenty-four) reported to the commanding officer. The top echelon at Percy Jones contained no nursing service, but it had directors of supply, personnel, and individual services. The standard plan placed the first two in the second echelon and had no separate individual service. On the other hand, no reconditioning council appeared on the Percy Jones chart. The standard plan provided for an admissions and dispositions office directly

STANDARD ORGANIZATION OF CONVALESCENT HOSPITALS (ASF)

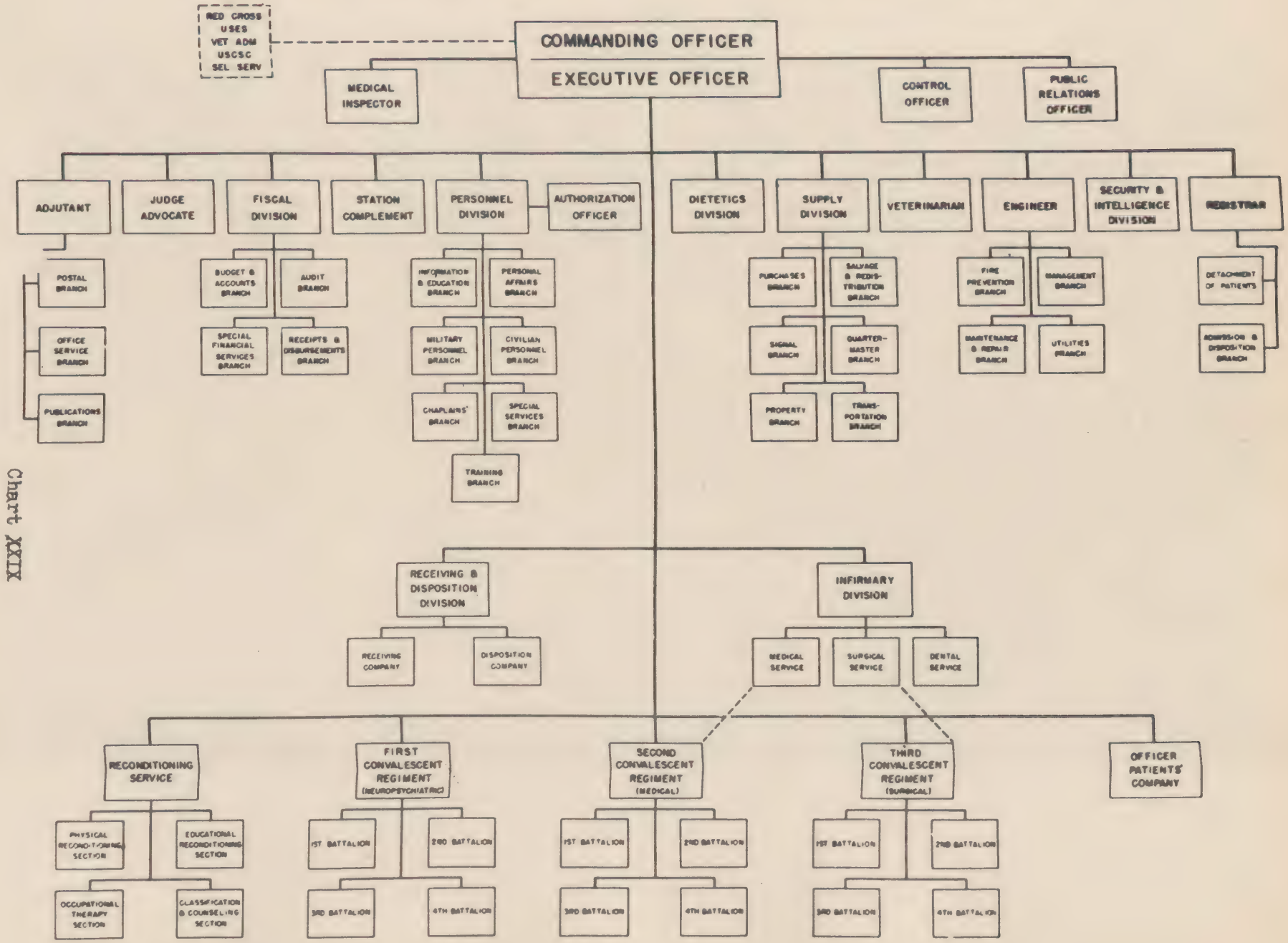


Chart XXIX

under the registrar. At Percy Jones the general hospital, annex, and convalescent hospital each had such an office. These offices operated under the jurisdiction of the center's post surgeon, but the registrar maintained liaison personnel at each one to forward clinical charts on patients disposed of and to coordinate the flow of records between the installations.[65]

At the end of 1945 the other hospital centers still showed considerable variation in structure among themselves. As guides to uniformity they had War Department Circular 105 of 4 April 1945 (above, p. 154), the rather sketchy Army Service Forces chart issued a few days later (above, Chart XXVI), and the example of Percy Jones which had been called to their attention in July 1945. None of these, however, was followed very strictly, probably owing to differences of opinion and local requirements. Some of the similarities and divergencies in organization appear on comparing the structure of the Wakeman, Brooke, Carson, and Butner centers.

All four were located on posts, which performed certain functions for them. Thus at Brooke the engineer, fiscal, and judge advocate services were post activities; at Butner these services as well as supply (except medical supply) were likewise furnished by the post. The top echelon had four components at each center as compared with six in the unpublished standard plan and at Percy Jones. These included a control and a public relations division in all cases; the other two constituents were a chief of professional services and a veterinarian at Brooke, an acting judge advocate and medical inspector at Wakeman, a medical inspector and veterinarian at Carson, and a post surgeon and medical inspector at Butner. None of these centers except Brooke had a director of professional services for the whole installation, one of the distinctive features of the standard plan and the set-up at Percy Jones. On the second (administrative) echelon Brooke had seventeen components, Wakeman eleven, Carson ten, and Butner nine. The figure for The Surgeon General's plan was eleven and for Percy Jones fifteen.

One feature of the organization at all four centers was noticeably different from the standard plan. The latter provided, for purposes of administration in the general hospital, only an administrative assistant (in addition to the commander, who of course was present at all installations). Brooke General, on the other hand, had an executive officer, an adjutant, a medical department detachment, and a chaplain. Carson General had the same, except that a detachment of patients office replaced the chaplain. At Butner the general hospital administration included an adjutant, admissions and dispositions office, dietetics division, Red Cross, and detachments of patients, enlisted men, and WACs. Wakeman General was the

most elaborately organized of all, with an adjutant's office composed of five branches (file, message center, hospital orders, reproduction, and information), a patients' administration division of four branches (detachment of patients, registrar, separation and classification, and patients' personnel), a supply division, a mess division, an individual services division with special services, personal affairs and chaplain's branches, a personnel office, and several medical detachments.

The administrative side of the convalescent hospitals at these centers was somewhat similarly organized, again in contrast with the standard plan. Thus the administrative section at Brooke comprised information, personnel, consolidated property, and inspector's offices. Butner Convalescent had an adjutant, executive officer, commanding officers of the medical detachment and detachment of patients, and Red Cross. The convalescent hospital at Carson was administered by an executive officer, supply officer, and medical detachment. The organization at Wakeman included an adjutant, personnel officer, individual services division, receiving divisions, patients administration division, separation division, mess division, supply division, and medical detachment headquarters. Several of these were subdivided into a number of branches.[66]

From the foregoing description it will be seen that hospital centers were no more uniform in organization than general or regional hospitals. In the case of hospital centers the diversity could be accounted for partly on the ground that no authoritative standard plan for their guidance was ever published.

* * * * *

In dealing with the organization of general and related hospitals the story has been carried to the end of 1945, somewhat beyond the point to which the account of service command headquarters organization was brought in the previous chapter. The following chapter will restore the balance and continue the narrative through the early months of 1946.

NOTES ON CHAPTER XI

[1]AR 170-10, 4 c (1) (p), 22 Jul 1942; AR 40-600, 2, 6 Oct 1942.

[2]Information from Lt. Col. William T. Smith, Hospital and Domestic Operations Division, SGO, 12 Apr 1946.

[3]Wadhams Committee, Recommendation No. 27 (Historical Division, SGO). Copies of the above correspondence are attached.

[4]Information from Lt. Col. John R. Thompson Jr., Hospital and Domestic Operations Division, SGO, 12 Apr 1946.

[5]Ibid., information from Mr. (formerly Major) L. T. Roach, Control Division, SGO, 15 Apr 1946.

[6]Ibid.

[7]Radio from Assistant Professional Service, to CG, Fourth Service Command (Attention Service Command Surgeon), 2 Mar 1944 (Record Room, SGO, 323.7-5 /4th Service Command/ AA).

[8]Information from Lt. Col. Thompson, as above (footnote 4).

[9]Ibid.

[10]Asst SG to CG, Second Service Command (Attention Service Command Surgeon), 15 Feb 1945 (Record Room, SGO, 323.3 /2nd Service Command/ AA).

[11]Memo, Deputy SG to CG, ASF, 14 Mar 1945 (Record Room, SGO, 300.7).

[12]Information from Mr. L. T. Roach, 15 Apr 1946, as above (footnote 5).

[13]TM 8-262, p. 1.1.

[14]Cf, above p. 103.

[15]Cf, above p. 104.

[16]TM 8-262, p. 1.4.

[17]Ibid., pp. 1.5 ff.

[18]Ibid., pp. 1.14 - 1.17.

[19]In Historical Division, SGO.

[20]WD Cir. 140, 2a, b, e, 11 Apr 1944.

[21]ASF Service Command Conference, 27 - 29 Jul 1944, p. 39 (Record Room [classified files] SGO).

[22]Ibid., p. 293.

[23]TM 8-262, pp 1.21 - 1.30.

[24]Annual Report, ASF Regional Station Hospital, Fort Warren, Wyo., 1945 (Historical Div. SGO).

[25]Annual Report, ASF Regional Hospital, Camp Lee, Va., 1945 (Historical Div., SGO).

[26]Cf Oakland (Calif.), Fort Monmouth, Fort Knox, and Camp Crowder Regional Station Hospitals, Annual Reports for 1945 (Historical Div., SGO).

[27]Annual Report, ASF Waltham Regional Hospital 1945 (Historical Division, SGO).

[28]Annual Report, ASF Regional Hospital, Fort Benning, Ga., 1945 (Historical Division, SGO).

[29]TM 8-260, p. 7.

[30]Convalescent hospitals attached to the combat forces had existed for some time previously.

[31]Speech of the SG at ASF Service Command Conference, 27 - 29 Jul 1944 (Record Room, SGO).

[32]The Camp Carson Station Hospital was redesignated a convalescent hospital, as was the AAF Hospital at Don Ce-Sar Place, St. Petersburg, Fla.

[33]WD Cir 140, 1. g., 2. e.

[34]WD Cir. 228, Sec II, 7 Jun 1944; 352, Sec III, 30 Aug 1944; 454, Sec II, 29 Nov 1944.

[35]ASF Cir. 419, 22 Dec 1944.

[36]Wakeman, Brooke, England, and Percy Jones General and Convalescent Hospitals, Annual Reports for 1944 (Historical Division, SGO); CG, Percy Jones General and Convalescent Hospital to Lt. Col. James T. McGibony, Hospital Division, SGO, 27 Feb 1944 (Record Room, SGO, 323.3 [Percy Jones General Hospital] K).

[37]Record Room, SGO, 353.9; information from Lt. Col. James McGibony, 30 Apr 1946.

[38]Information from Lt. Col. McGibony and Lt. Col. Wm. T. Smith, Hospital and Domestic Operations Division, SGO, 30 Apr 1946.

[39]Representatives of Headquarters, ASF, were also present, but confined themselves to supporting The Surgeon General's delegates. (Information from Mr. R. R. Ranney, Control Division, SGO, 26 Apr 1946.)

[40]Ibid.

[41]WD Cir. 105, II, 1.

[42]WD Cir. 115, I, 3.

[43]ASF Cir. 135.

[44]9 Jul 1945 (Record Room, SGO, 323.3 /1st, 3rd, 4th, 5th, 7th and 9th Service Commands/ AA).

[45]Acting Surgeon, First Service Command, to SG, 24 Jul 1945 Record Room, SGO, 323.3 /1st Service Command/ AA); CG, Fourth Service Command, to SG, 28 Jul 1945 (Record Room, SGO, 323.3 /4th Service Command/ AA); Surgeon, Ninth Service Command, to Commanding General, ASF attention the SG, 26 Jul 1945 (Record Room, SGO, 323.3 /Percy Jones General Hospital/ K).

[46]Annual Report, Percy Jones Hospital Center, 1945, p. 3 (Historical Division SGO).

[47]Information from Maj. R. E. Garrett, Control Division, SGO, 2 May 1946. Maj. Garrett was largely responsible for planning the new organization at Percy Jones.

[48]Acting Surgeon, First Service Command, to SG, 24 Jul 1945 (Record Room, SGO, 323.3 /1st Service Command/ AA); CO, Hospital Center, Fourth Service Command, to CG, Fourth Service Command, 19 Jul 1945 (Record Room, SGO, 323.3 /7th Service Command/ AA); Surgeon, Ninth Service Command, to CG, ASF, attention SG, 26 Jul 1945 (Record Room, SGO, 323.3 /Percy Jones General Hosp/ K);Surgeon, Seventh Service Command, to SG, 24 Jul 1945 (Record Room, SGO, 323.3 /7th Service Command/ AA).

[49]Draft of Proposed War Department Technical Manual, Administration of Fixed Hospitals, Zone of the Interior, Chapter I, Hospital Administration, Section 4 (a copy in the files of the Control Division, SGO, dated Jan 1946), p. 2.

[50]Ibid., p. 32.

[51]Ibid., p. 27

[52]Ibid., pp. 6 - 7

[53] Ibid., p. 26 - 27.

[54] Ibid., pp. 7 - 8.

[55] Ibid., p. 12.

[56] Ibid., p. 11

[57] Ibid., p. 22.

[58] Ibid., p. 21.

[59] Ibid., pp. 28, 32.

[60] Ibid., pp. 33-34, 35.

[61] Ibid., p. 34.

[62] Draft of Proposed War Department Technical Manual, Administration of Fixed Hospitals, Zone of the Interior, Chapter I, Hospital Organization, Section 3, Standard Functional Organization of Convalescent Hospitals (ASF). Jan 1946 (a copy in the files of the Control Division, SGO).

[63] Memo, Chief, Administrative Branch, Hospital and Domestic Operations Division, SGO, to Director, Control Division, SGO, 5 Mar 1946 (files, Control Division, SGO).

[64] The SGO plan for separate convalescent hospitals represented essentially a combination of the administrative organization of the general hospital (described in TM 8-262) with the convalescent structure of the hospital center just dealt with. The stated administrative functions were, with one or two exceptions, almost the same, word for word, in both cases. One difference was that the convalescent hospital had a linen exchange branch as part of the supply division (although this is not shown on the chart). Also, the admissions and dispositions branch of the registrar's office (unlike that of the general hospital) had only two functions: it "prepares the Consolidated Ward Morning Report and Admission and Disposition Sheets" and "maintains Statistical Locator File." The main difference on the professional side was that the separate convalescent hospital contained an infirmary division, which "a. Furnishes hospital type treatment to all patients as required. b. Maintains clinics for consultation purposes as required. c. Operates medical, surgical, dental and such other services as may be required by the needs of the patients assigned to the hospital. d. Maintains and processes clinical records and progress charts." Otherwise the professional functions of the separate convalescent hospital were given as almost identical to those of the convalescent part of the hospital center.

[65]Annual Report, Percy Jones Hospital Center, 1945, p. 159 (Historical Division, SGO).

[66]Annual Reports, Brooke, Butner, Carson and Wakeman Hospital Centers, 1945 (Historical Division, SGO).

CHAPTER XII

THE SURGEONS' OFFICES, 1944 - 1946; DEMOBILIZATION AND POSTWAR ORGANIZATION IN THE SERVICE COMMANDS

The Service Command Surgeons' Offices and the Post Surgeons' Offices

After the restoration of the service command surgeon to a position of direct responsibility to the service commander in December 1943 (above, Chapter X), no further changes in the former's status occurred during the rest of the war. Some time afterward, however, actions were taken which affected or might have affected the surgeon's position. Thus the Commanding General of the First Service Command in September 1945 recommended rescinding the mandatory provisions of the Army Service Forces manual (M-301) so far as they applied to headquarters organization in order that service commanders might have "maximum latitude" in remodelling their headquarters to meet changed requirements. This recommendation, however, was disapproved by Headquarters, Army Service Forces.[1] The reorganization of the War Department in June 1946 involved the service command surgeons as well as all other members of the Medical Department and will be considered further on.

The status of the service command surgeon, therefore, remained unchanged up to June 1946. His functions, however, together with those of the post surgeon, were somewhat modified subsequent to 1943. Certain changes were introduced shortly after V-E Day by a revision of the Army Service Forces organization manual (15 June 1945). In the case of the service command surgeon these changes were minor. To the clause giving him authority to supervise hospitalization and medical service was added "dental service, . . . sanitary measures, and other protective measures." The clause on veterinary inspections was elaborated, assigning him responsibility for making "nutritional evaluation of soldiers' ration and daily menu" and "inspection of mess operations from the standpoint of health." Where formerly the quartermaster had been "responsible for all veterinary inspections within the Quartermaster Depots and within the metropolitan area in which the Quartermaster Depot is located," the surgeon now "supervises inspection service incident to Service Command procurement of dairy, meat, and food supplies, and, as requested by the Quartermaster General, assists in inspection incident to other procurement of dairy, meat, and food supplies." This restored almost the precise wording of the manual of 24 December 1942.

Certain added responsibilities had already been placed upon the service command surgeons in connection with planning and carrying out demobilization after the anticipated defeat of Germany and Japan. As early as December 1943 the Office of The Surgeon General, in its own demobilization plan, provided that each service command surgeon should "prepare detailed plans for the functions which he will be called upon to perform during demobilization".[2] Somewhat later Army Service Forces Headquarters issued a demobilization plan for Period I (the interval between the expected defeat of Germany and that of Japan). As implemented early in 1945 by the various service commands, this plan assigned certain specific duties to the surgeon. In the Third Service Command, for example, he was directed to establish a procedure for the evacuation of sick and wounded and to accelerate their movement as required.[3] In the Fourth Service Command all technical services (including the surgeon's office) were to take action for "determination of surplus command installations, redistribution of excess military property, arrangement for proper rehabilitation, repair or servicing of military property, establishment of a reserve of serviceable training equipment for redeployment training in the United States," and "reduction or elimination of activities during Period I."[4]

Almost a year after the end of the war (April 1946) one important phase of the service command surgeon's authority was abolished: his command of general, regional, and convalescent hospitals. The circumstances of this change will be dealt with later.[5]

Between 1942 and 1945 the functions of the post surgeon, as stated in successive organizations manuals, varied less than those of the service command surgeon. The 10 August 1942 edition of the manual described the post surgeon's functions as

a. Furnishing medical service and supplies on the post.

b. Operation of dental clinics on the post.

c. Inspection of meat, dairy products, and forage on the post and the conduct of other veterinary activities, including the operation and maintenance of veterinary station hospitals.

d. Operation of station hospitals, including tactical hospitals when placed under service command control.

e. Conduct of evacuation activities.

f. Inspection of the sanitation and cleanliness of the post.

The edition of 15 December 1943 amplified the reference to the supply function: the surgeon

g. Requisitions, stores, and issues medical supplies under the direction of the Supply Division.

h. Advises the Director of Supply on the maintenance and repair of medical equipment and classifies such equipment as serviceable or unserviceable.

The edition of 15 June 1945 dropped the last function and added: "Disposes of materiel returns and excesses according to latest instructions," "Responsible for the maintenance of proper stock levels," and "Maintains first and second echelon repair of medical technical equipment." The duties as to inspecting forage and conducting "other veterinary activities" ("c" above) were eliminated. This manual also dropped the reference to tactical hospitals in "d". (The previous manual /December 1943/ had slightly changed this clause to read, "Operates and trains station hospitals, including numbered medical units.") The clause now read simply, "Operates the station hospital, infirmaries, and dental clinics." Finally, a new function was added: "Advises the Post Commander on all medical matters; conducts necessary inspections to insure that policies and instructions are applied and carried out particularly as to training, supply, maintenance, salvage and reclamation."

While the functions of both the service command surgeons and the post surgeons varied somewhat during 1944-1946, the changes were less radical than those which occurred in the internal structure of the service command surgeons' offices. However, no complete uniformity of structure among these offices was ever achieved. As we have seen (above p. 136) the Office of The Surgeon General at the end of 1943 had suggested a standard type of organization based on its own administrative structure. During 1944 and 1945 that office itself underwent some structural changes. To its main services--administrative, personnel, operations, supply, and professional--preventive medicine (formerly a division of the professional service) and a number of consultant's divisions were added during 1944. The available charts from seven of the nine service commands indicate that none of the surgeons' offices conformed exactly to The Surgeon General's organization, even so far as this top echelon was concerned. The nearest approach to it was in the Eighth Service Command during 1944. Even here, however, the consultants were carried as a section of the professional service branch, and by the end of 1945 the organization had been recast

almost out of recognition. The only main elements like those of The Surgeon General's Office were now the administration and professional branches. To these had been added an assignment branch (similar to personnel) and a hospital branch. Supply and operations were now sections of the latter, while veterinary and preventive medicine became sections of the professional branch.[6] In the First Service Command the Surgeon's Office showed an approach to the structure of The Surgeon General's Office between 1943 and 1946, at least so far as nomenclature was concerned. The chart for 15 May 1943 exhibits six sections which later disappeared: hospitalization, evacuation and industrial hygiene; medical inspections; medical service; sanitary; venereal disease control; and management; and four others which were retained in 1945: supply, Army nurses, veterinary, and dental. The chart for 15 October 1945 includes the latter group together with personnel, preventive medicine, administrative, consultants, and operations (combined with supply), which were parallel to services of The Surgeon General's Office.[7] As we have seen (above p. 136), the Surgeon of the Sixth Service Command stated in his report for 1943 that his office had an organization "approximating that of The Surgeon General." But his chart for 20 March 1945 does not indicate that the approximation at that time was very close.[8]

Reorganization of the War Department in Relation to the Service Command Medical Establishment

At a service command conference held late in January 1946 the question was raised whether a standard organization (presumably a new one) would be established for the service commands, and whether it would be coordinated with Headquarters, Army Service Forces. The reply was that the organization of Army Service Forces and the service commands was being studied by the War Department and that no definite answer could be given at that time.[9]

The study referred to had been inaugurated in October 1945 with the appointment of a board of officers, known as the Patch Committee, whose purpose was to determine the future organization of the entire War Department. This board, appointed on 19 October 1945, was reconstituted on the following 6 December under the presidency of Lieutenant General W. H. Simpson.[10] In its report of 28 December 1945 (with revisions as of 18 January 1946) the board made numerous proposals. Among other things, it expressed the belief that

> with the personnel restrictions which will exist in the postwar Army, the number of large headquarters should be reduced to the minimum. As a material step in this direction and as a further measure of decon-

tralization it is believed that the nine Service Commands should be discontinued and replaced by six Army Areas. . . The functions of the Service Commands with respect to ground troops and stations, excluding exempted stations and activities, would be taken over by the Army Areas, each under command of an Army commander, who would be responsible for area supervision and could report to the Commanding General, The Army Group, on all training matters and on the tactical preparation of troops, and direct to the War Department on all administrative, supply and service matters. . . . Stations and establishments that experience has indicated should be under command of appropriate chiefs of services would be exempted from the Army commanders.[11]

The report was submitted for comment to the chief officers of the War Department, including The Surgeon General. Meanwhile, the Hospital and Domestic Operations Division of The Surgeon General's Office had recommended

that all general hospitals be placed under direct control of The Surgeon General. With the reduction in the number of general hospitals it is believed that better control and maintenance of standards of care desired by The Surgeon General can be maintained if direct control is kept within the Office of The Surgeon General.[12]

In his comment on the Simpson Board's Report The Surgeon General adopted this suggestion, recommending that explicit provision be made for placing general hospitals under the command of The Surgeon General.[13]

A committee headed by the Acting Assistant Chief of Staff, G-3, took a different stand. It believed that

general hospitals and Finance offices should be continued under the Armies. . . During the war both general hospitals and United States Finance offices operated under the jurisdiction of the Service Commands. . . In accordance with the decentralization principle stated in the Report of the Board . . . the Committee is of opinion that their activities should remain under the Armies, and that it would be a backward step in decentralization to place them under the jurisdiction of the appropriate Chiefs of Services.[14]

The Simpson Board, however, rejected the suggestion at least in part:

The Board does not concur in the recommendation that general hospitals be continued under the Army

> Areas. It is the belief of the Board that The Surgeon General is unduly hampered in the performance of his mission if general hospitals are under the command of the Army Areas. This is particularly true with respect to the assignment and utilization of medical and surgical specialists. Accordingly the Board will recommend to the Chief of Staff that general hospitals be classified as exempt stations.[15]

On 14 March 1946 The Surgeon General was notified by the War Department General Staff that "classification of general hospitals and convalescent hospitals as exempted stations under the command of The Surgeon General is concurred in."[16] A month before the directive on reorganizing the War Department appeared, an Army Service Forces circular ordered the transfer of all hospital centers, general hospitals, and convalescent hospitals from the control of the service commands to that of The Surgeon General's Office, effective 15 April 1946.[17] "Housekeeping" matters such as utilities, postal service, finance, and quartermaster activities at these institutions remained under the supervision of the service commands.[18]

The Simpson Board's complete plan for War Department reorganization was published on 14 May 1946, to become effective on 11 June following.[19] Besides assigning the command of general hospitals to The Surgeon General (a step already taken), the plan touched upon the status and functions of the Medical Department in the service commands in several other ways. By substituting six Army areas for the nine service commands, it reduced the number of service command surgeons and abolished their old title. With the elimination of the Army Service Forces command, it altered the relations between the surgeons and the War Department General Staff. For their medical responsibilities, the Army (area) commanders were to "communicate direct with the War Department."

These responsibilities appear to have differed little from those previously assigned to the service commanders and their surgeons. They comprised

> Medical and dental service (except at medical centers and general hospitals) including --
>
> (a) All hospital facilities, except facilities assigned to the Army Air Forces, including regional and station hospitals, general dispensaries, and medical and dental laboratories.
>
> (b) Industrial medical program.

(c) Preventive medicine, including sanitation and hygiene, communicable disease control, venereal disease control, nutrition, and liaison with civil health agencies. . .

Veterinary services, except as provided below.

(a) Veterinary services at quartermaster and general depots charged with supply of food products and veterinary food inspection within the metropolitan areas in which such depots are located.

(b) Veterinary service at quartermaster remount depots and remount area headquarters.

The medical responsibilities of Army commanders at exempt (Class II) installations were similar to the above, except that the "industrial medical program" was not mentioned. Nor were any medical functions for Army commanders indicated at Air Forces (Class III) installations. The provision regarding sanitation (ASF Organization Manual, 15 December 1943, 402.02) did not reappear in the new directive.

The account of medical organization in the service commands may well conclude with the projected ending or transformation of the service commands themselves. By 1946 the regional structure of the Army had returned, in some respects, to its pre-war starting point. The service commands were preceded and were to be followed by mixed tactical and service organizations: the corps areas and the Army areas. The regional surgeons had been members of the corps area special staff; long before the end of the war they returned to a similar if not to precisely the same position. The general hospitals, after a period of subordination to the service commanders, were restored to the control of The Surgeon General. In the first case the cycle appears to represent, in large part, the shift from peace to war and back again. In the two other instances, it was the result of experience gained by trial and error.

NOTES FOR CHAPTER XII

[1]Memo for Director, Control Division ASF, from Deputy Chief of Staff for Service Commands, ASF, and reply, 21 Sept 1945 (Administrative Records, C. G., ASF [321 Service Commands]).

[2]The Surgeon General's Tentative Demobilization Plan, 7 December 1943, p. 3 (Historical Division, SGO).

[3]Office of CG, Third Service Command to CGs and COs, Posts, Camps and Stations, Third Service Command, 27 April 1945 (files of Planning Branch, Hq., ASF).

[4]Fourth Service Command Plan for Period I, 23 April 1945 (files of Planning Branch, Hq. ASF).

[5]Below, p.

[6]Annual Reports, Eighth Service Command, 1944, 1945 (Historical Division, SGO).

[7]First Service Command, Organizational and Functional Charts, 15 May 1945. Chart 2. Annual Report, First Service Command, 1945 (Historical Division, SGO).

[8]Annual Report, Sixth Service Command, 1944 (Historical Division, SGO).

[9]Eighth Semi-Annual Service Command Conference, 24-25 Jan 1946 (Record Room, SGO).

[10]Memo for Lt. General Simpson, etc., from Asst Deputy Chief of Staff, War Department, 29 Nov 1945 (files of Deputy Director of Plans, SGO).

[11]Report of Board of Officers on Organization of War Department, 28 Dec 1945, with revisions as of 18 Jan 1946 (files of Deputy Director for Plans, SGO).

[12]Memo for record by Deputy Director, Special Planning Division, SGO, 8 Jan 1946 (files of Deputy Director for Plans, SGO).

[13]SG TO CG, ASF, 5 Feb 1946 (files of Deputy Director for Plans, SGO).

[14]Memo for President of Board of Officers for Organization of the War Department, 4 March 1946 (files of Deputy Director for Plans, SGO).

[15]Memo for Brig. General C. L. Eberle, Acting Asst. Chief of Staff, G-3, from Lt. General Simpson, 5 March 1946 (files of Deputy Director for Plans, SGO).

[16]Memo for SG from Deputy Chief of Staff, War Department (Control), 14 March 1946 (files of Deputy Director for Plans, SGO).

[17]ASF Cir. 92, Part Two, 11 April 1946.

[18]Office Order 134, SGO, 18 April 1946.

[19]WD Cir. 138, 1946.

CHAPTER XIII

CONCLUSION

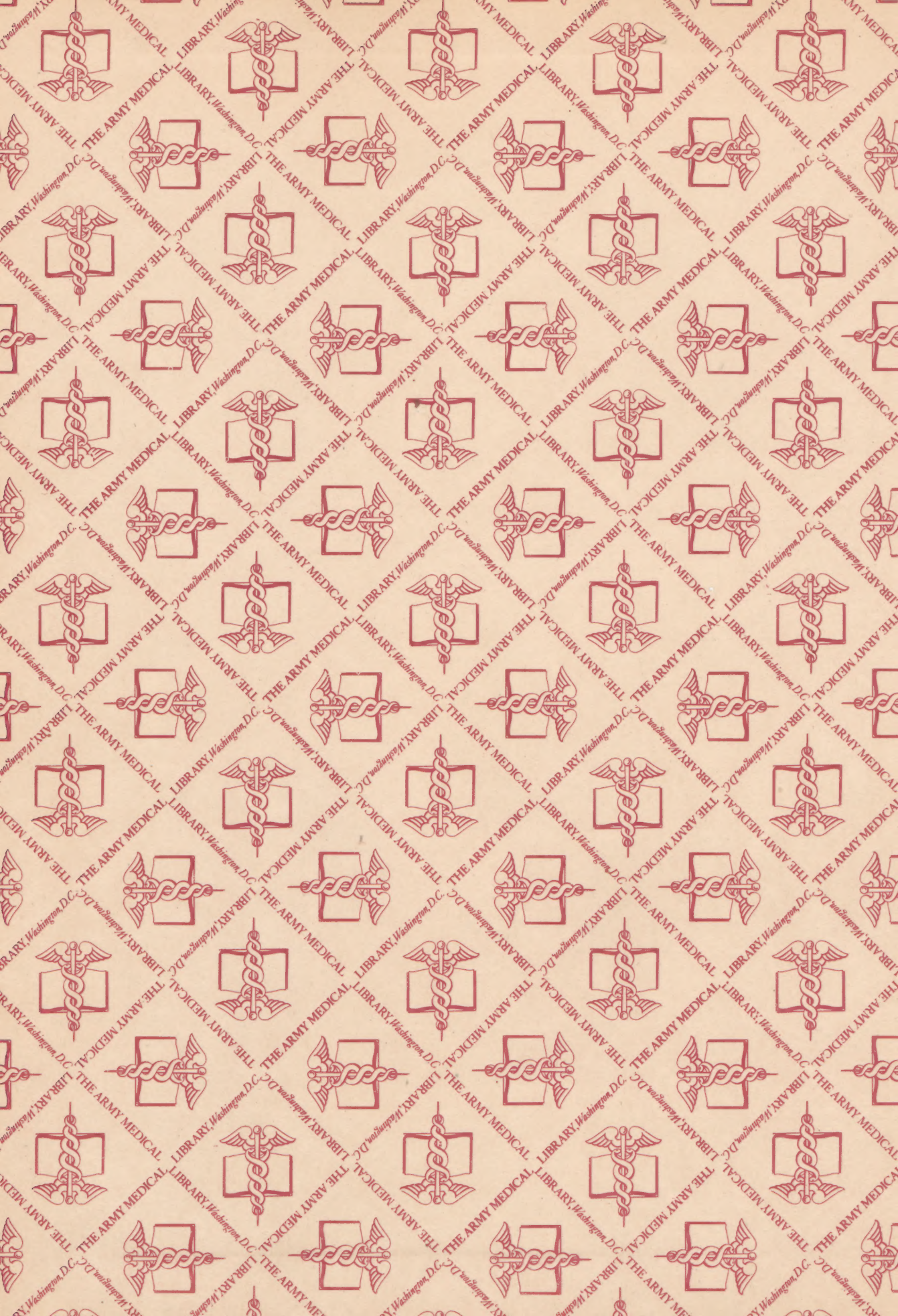
It is easier to trace the changing outlines of Medical Department organization than to find reasons for the changes. An old branch withered away or a new one sprouted, often with no explanation of the process in the form of a written record or even as a recollection of the persons concerned. Thus while conversations and verbal understandings could produce important and speedy transformations in an office structure, such agreements left small pickings for history. Even where documents exist there is sometimes a strong indication that they do not tell the whole story. Influences of a personnel nature may have been decisive in producing certain realignments and delegations of authority, but they were not apt to find their way into the record.

As the foregoing chapters indicate, however, at least one main purpose is discernible behind many changes in Medical Department administration during and after the war period; namely, the decentralization of authority both in the headquarters and the local organization. So far as structure was concerned, this meant a reduction in the number of services reporting to a particular chief--The Surgeon General, the commanding officer of a hospital, etc.--and the devolution of greater authority on lower echelons. This process, however, did not prevent the establishment of the Operations Service in the Office of The Surgeon General as the coordinating center of Medical Department activities. All functions of The Surgeon General's Office were gradually brought into alignment for this purpose, and the Chief of the Operations Service became The Surgeon General's principal aide in carrying forward the mission of the Medical Department.

The policy of decentralization was not always realized in practice to the extent at first considered feasible by higher authority; occasionally a project was abandoned or considerably watered down after a period of trial and sometimes before it could be put into effect. Instances of this are the restoration of the service-command surgeons to their staff positions and the working out of a model hospital organization that left more direct supervision in the hands of the hospital commander than was at first thought desirable.

Under the policy of decentralization an attempt was made to standardize, in a general way, the plan of headquarters organization, whether the headquarters happened to be the Office of The Surgeon General, the service-command surgeons' offices, or the offices of hospital commanders.

Some uniformity of this sort was achieved, but it was far from complete—much less so than the directives of the Commanding General, Army Service Forces, and The Surgeon General seemed to envisage. But in spite of this deficiency, if such it was, business could be and frequently was transacted outside the formal channels of authority. Organization had the power to expedite or obstruct, but not to insure or utterly prevent, the effective conduct of medical affairs.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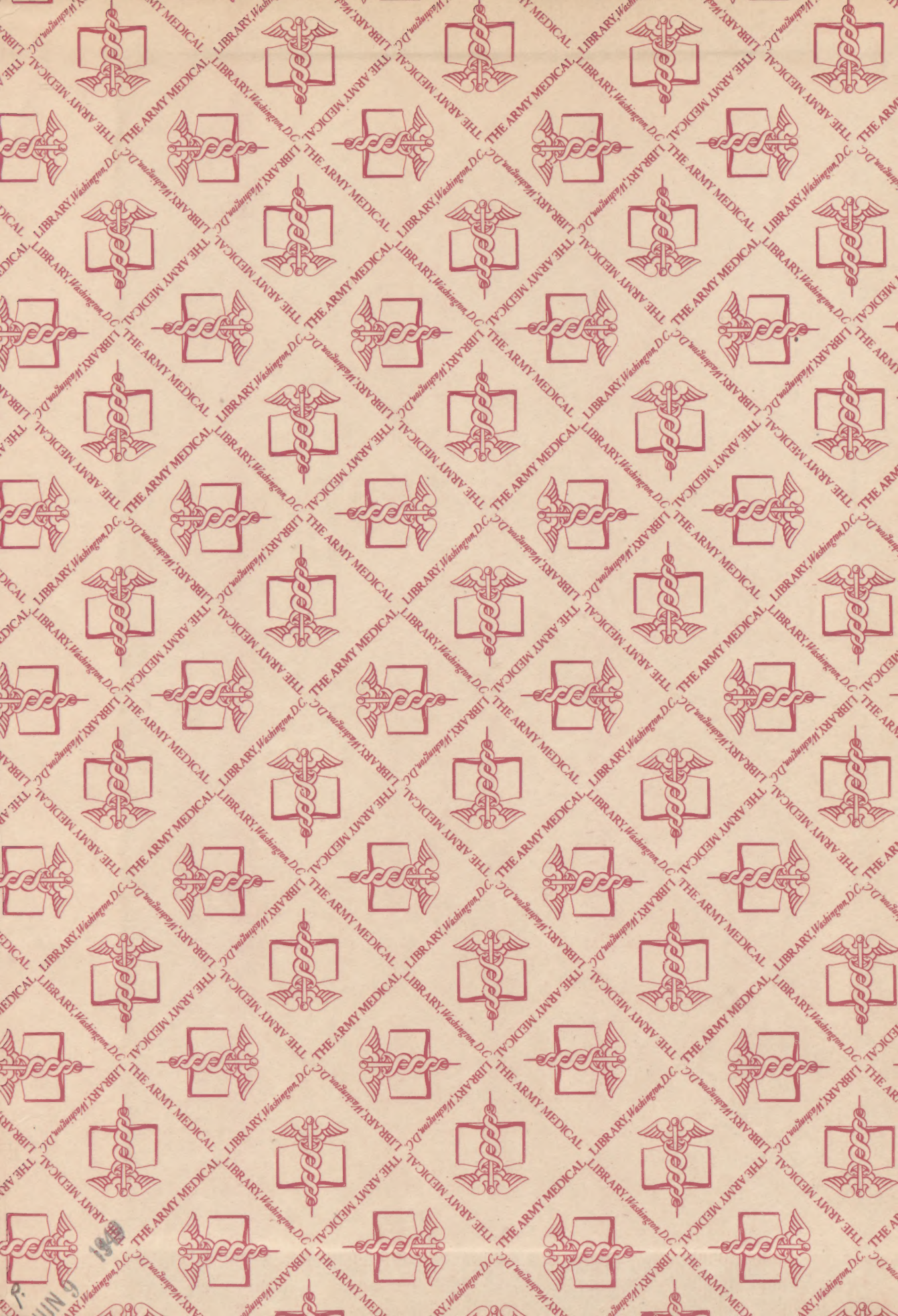
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